

Final Report on Implementation of the Hospital Authority Review Action Plan



醫院管理局
HOSPITAL
AUTHORITY

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1. Following the release of the report of the Steering Committee on Review of the Hospital Authority (HA) in July 2015, which aimed to explore measures for enhancing the cost-effectiveness and quality of services, HA formulated a detailed action plan in October 2015, comprising a total of 124 action items for implementing the 10 HA Review recommendations on the five priority areas of (a) management and organisation structure; (b) resource management; (c) staff management; (d) cost effectiveness and service management; and (e) overall management and control. The target was implementation in three years' time, i.e. by late 2018.

2. Through the efforts in the past three years, HA has largely completed all the action items according to the HA Review Action Plan and on schedule, while some are on-going and continuous initiatives. The major results achieved on the HA Review Action Plan for implementing the recommendations of the Steering Committee on Review of HA (which are also recapped below) are highlighted in the ensuing paragraphs, while a summary table of the specific action items is provided in **Appendix A**.

Recommendation 1: Strengthening governance (R1 & R7(a))

(a) The HA Board, being the managing board, should play a more active role in leading and managing HA.

Recommendation 7:

(a) The HA Board, being a managing board, should play a more active role in setting key standards and targets to –
(i) monitor the overall performance and service provision for public accountability; and
(ii) facilitate management decision to improve performance and drive best practices.

HA Board as managing board

3. The Board has made sustained efforts to reinforce corporate governance and enhance practices to ensure accountability and stewardship of HA's resources and effective management of services. The Board and its functional committees conduct annual agenda forecast along different strategic and functional dimensions for guiding their operations throughout the year, and extra steps are taken to proactively and specifically align the agenda forecast and planning with their respective Terms of Reference in order to further ensure that they can sufficiently address important issues under their Terms of Reference. The role and participation of the functional committees are also strengthened in setting key standards, driving for best practices and monitoring performance. Subject Directors/Heads (Ds/Hs) engage the Board's Executive Committee (EC) at early stage in formulation of strategies, directions and policies. On-going efforts are made to facilitate the HA Board in leading and managing HA, e.g. various arrangements are made to facilitate Members' understanding of HA's policies and operations, including briefings on selected topics, direct discussions on areas of strategic importance, visits, talks, etc. To drive for continuous improvement, the survey questionnaires for annual self-assessment by the Board and functional committees was further refined and streamlined in 2018.

Recommendation 1 : Re-delineation of cluster boundaries

- (b) The existing arrangement of having seven clusters should be maintained;
- (c) The **delineation of cluster boundary**, particularly those of the Kowloon clusters, should be refined having regard to the supply and demand for healthcare services as well as the hospital development/redevelopment plans in the respective cluster; and
- (d) In reviewing the cluster boundary, opportunities should be taken to **maximise coherence on vertical integration of services** to ensure continuity of care for patients within the same cluster.

Re-delineation of cluster boundaries

4. HA has re-grouped Wong Tai Sin district and Mong Kok area, involving Kwong Wah Hospital (KWH), Tung Wah Group of Hospitals Wong Tai Sin Hospital (WTSH) and Our Lady of Maryknoll Hospital (OLMH), together with the five General Outpatient Clinics (GOPCs) and community services in the concerned communities, from Kowloon West Cluster (KWC) to Kowloon Central Cluster (KCC) since 1 December 2016 to maximise coherence on vertical integration of services for the patients in the concerned districts and to facilitate patients from local communities to have continuity of care in their residential vicinity. The objective of the clustering concept of facilitating patients from local communities to have continuity of care in their residential vicinity is better realised, although cross-cluster utilisation of services is still observed given the historical development of the hospitals, patients' preference, convenience and proximity, as well as availability of specialised tertiary services in the individual clusters etc. Further details of the implementation process and the outcome, including the formulation of high level plans for clinical service reorganisation after re-delineation of cluster boundary for KCC and KWC, are set out below.

5. After the smooth implementation of the administrative arrangement on 1 December 2016 for the change of cluster identity from KWC to KCC for the concerned staff, hospitals and service units, the cut-over of non-clinical support services between the two clusters was put into effect on 1 April 2017 uneventfully. All transactions and activities for the affected hospitals and service units were then taken over by KCC. The manpower providing cluster support to the affected hospitals and service units together with the related budget, had also been transferred from KWC to KCC on the same date. To help the two clusters tide over the transition, a time-limited top-up funding of two years amounting to \$11 million was allocated to the two clusters.

6. Reorganisation of clinical services after the cluster boundary re-delineation exercise, mainly involving clinical services with referral system cutting across KCC and KWC, is in progress. The two clusters have applied the same principle as in other service reorganisation, that is, the change is to bring benefits to either patients or management / operations at clusters so that patients could have better access to service at their proximity; and HA could achieve better economies of scale and help streamline workflow in service

provision. Guided by the above principles of clinical service reorganisation and the respective Clinical Services Plans (CSPs)¹, high level plans for clinical service reorganisation for KCC and KWC were formulated, which were separately reported to the Board in November 2017 and January 2018 respectively. The high level plans provide an outline on the short, medium and long term plan for service reorganisation to facilitate the provision of continuous care for patients in the same cluster throughout the patient journey. A phased approach for implementation is adopted around the three building blocks of :

- (a) acute-convalescent care;
- (b) primary and community services; and
- (c) direct patient care, including clinical supporting services.

Acute-convalescent care

7. Bed capacity is a major issue of concern following the cluster boundary re-delineation exercise. A total of 1 953 hospital beds² are re-grouped from KWC to KCC. Among the hospital beds regrouped from KWC, convalescent / rehabilitation and infirmary beds constituted a relatively higher proportion than acute beds. As convalescent / rehabilitation and infirmary beds play an important role in acute-convalescent care which focuses on the management of patient flow from acute to non-acute hospitals under a service network where patients can receive continuous care in their residential vicinity, insufficient provision of convalescent and rehabilitation beds has brought challenges to KWC. Thus, capacity building is one of the utmost tasks in KWC.

8. To address the said situation in KWC, HA has formulated short-term strategies to rationalise space utilisation in Princess Margaret Hospital (PMH) and Caritas Medical Centre (CMC), whilst also increasing the rehabilitation capacity in Yan Chai Hospital (YCH) and Lai King Building (LKB) of PMH. The medium-term strategies include the planned opening of an additional 400 convalescent beds upon redevelopment of LKB of PMH, as spelt out in the Ten-year Hospital Development Plan (HDP), for addressing the projected service demand for in-patient and rehabilitation services in the cluster. As for longer-term strategies, capital planning on bed capacity in relation to future service directions will be further deliberated in the KWC CSP under preparation.

9. In KCC, following a collaborative approach to ensure comprehensive care and enhance service linkage for patients at geographical proximity, the service network of the partnering hospitals, with a strengthened collaboration between acute and non-acute hospitals, has been outlined, as summarised below:

- (a) Kowloon Hospital (KH) will serve as an extended care hospital in KCC to provide convalescent and rehabilitation services for patients transferred from KWH; and

¹ The CSP maps out the clinical strategies, intended service development and future service models, as well as role delineation of individual hospitals within the cluster. At the time of the development of the service reorganisation plan, KCC's CSP has already put in place, while that for KWC is under formulation.

² Bed complement as at 31 December 2016

- (b) Queen Elizabeth Hospital (QEH) / the new acute hospital (NAH) in the Kai Tak Development Area (KTDA) will form a service network with OLMH, WTSH and Hong Kong Buddhist Hospital (HKBH) to streamline and coordinate the patient pathways from acute to non-acute hospitals.

10. A pilot project to rationalise the acute-rehabilitation service arrangement for QEH/WTSH and KWH/KH was launched in early August 2015, where WTSH and KH each designated medical rehabilitation beds for cases referred by QEH and KWH respectively. Under this new patient-flow arrangement, target patients from Wong Tai Sin and Yau Tsim Mong Districts can receive acute-rehabilitation services in hospitals under the same district. With the smooth transition of the re-grouping put into effect on 1 April 2017, the pilot project was completed and the KCC management would overall review the acute-rehabilitation service arrangement with a view to extending to other specialties.

Primary and Community Services

11. Upon the re-delineation of the cluster boundary, KCC took over five GOPCs and two hospital-based GOPCs from KWC. Service provision of primary and community care is positioned as a district-based service in the local community. With the large scale of service provision under the prevailing cluster-based service model, the regrouping exercise has not posed much impact on KWC in terms of the number of clinics and service throughputs. On the other hand, the management structure of Family Medicine (FM) and GOPCs in KCC has been aligned for its provision of primary care services with a cluster-based management model. HA will closely monitor the situation and take the opportunity to enhance its service provision to patients at cluster level.

Direct Patient Care including Clinical Supporting Services

12. Delivery of clinical services on direct patient care has to be supported by a network of clinical supporting services. For each of the clinical supporting services, detailed analysis and assessment have been conducted to ensure sufficient capacity and resources for sustaining the support on clinical services in the cluster. Most of the services remain status quo at the initial stage. For services with cross-cluster support, the need for reorganisation would be assessed, while observing the principles that such change should only be initiated for the benefit to either patients or management / operations at clusters.

13. The high level plans for clinical service reorganisation will span across a good many years. KCC aims to complete the reorganisation plan to dovetail with the commencement of operation of the NAH in KTDA in around 2024-25. Before that, KCC will ride on the opportunities of the completion of the redevelopment projects of HKBH, KWH and OLMH, and take a phased approach for implementation. KCC will continue to plan and work out details through engagement and discussion with its stakeholders, including clinical teams and ex-governing bodies of its Schedule 2 hospitals. Resources, as and when necessary, will be bidden through the prevailing annual planning exercise.

14. For KWC, the upcoming KWC CSP will shed light on the cluster service model in the new KWC. In the interim, KWC will ride on the opportunity of this cluster boundary re-delineation exercise to review its services, with an aim to maximise coherence on vertical integration of services to ensure better continuity of care for patients within the cluster. Despite that capacity building will take time to realise, KWC will explore options, including

service reorganisation if benefits to patients and management / operations will be brought; and seeking resources for capacity building through the prevailing annual planning exercise, with priorities given to services with significant service volume, rapid growth rate and reaching critical capacity.

15. For those service gaps so identified after the cluster boundary re-delineation exercise, both KCC and KWC would explore opportunity for service reorganisation through the prevailing annual planning exercise. Both clusters have adopted a phased approach for formulation of their respective subsequent annual plans, which have also tied in with the progress of various hospital development / redevelopment plans in the respective clusters. Related annual plan proposals for 2019-20 are being prioritised in the pipeline.

Cross-cluster service utilisation

16. With the re-delineation of cluster boundary and the consequential service reorganisation by phases, HA has reviewed the distribution of population and hospital beds in KCC and KWC as well as their cross-cluster service utilisation for ascertaining the associated benefits from the cluster boundary re-delineation exercise. Key highlights of the review are as follows :

- (a) better balance in population distribution and reduction in cross-cluster utilisation between KCC and KWC

	Before Re-delineation		After Re-delineation	
	Population ³ Estimates as at mid-2014	Cross-cluster utilisation ⁴ 2013-14	Population ⁵ Projection as at mid-2017	Cross-cluster utilisation ⁶ 2017-18
KCC	0.5 million	62%	1.2 million	27%
KWC	1.9 million	13%	1.4 million	10%

Note: The difference in the sum of the population figures in KCC and KWC before and after the exercise is mainly attributed to population growth.

- (b) better balance in terms of number of hospital beds per 1 000 geographical population of catchment districts

	Before Re-delineation		After Re-delineation	
	Hospital Beds per 1 000 population ⁵ Estimates as at mid-2014	Bed Number as at 31 March 2014	Hospital Beds per 1 000 population ⁵ Projection as at mid-2017	Bed Number as at 1 April 2017
KCC	6.6	3 548	4.8	5 549
KWC	3.4	6 629	3.5	4 699

Note: A total of 1 953 hospital beds have been re-grouped from KWC to KCC with effect from 1 April 2017. The difference in the sum of bed number in KCC and KWC before and after the exercise is attributed to additional bed opened under annual plan programmes from 2014/15 to 2016/17 in KCC and KWC.

³ Population figures are based on the latest revised mid-year population estimates by the Census & Statistics Department and “Projections of Population Distribution 2015-2024” by the Planning Department.

⁴ Percentage of patients (in terms of inpatient discharges and deaths) living outside the catchment districts by hospital cluster.

- (c) more patients in Wong Tai Sin and Yau Tsim Mong districts can receive inpatient services in its catchment cluster viz. KCC

		Service Provisions ⁵ in KCC Hospitals	
		Before Re-delineation 2013-14	After Re-delineation 2017-18
District of Residence	Wong Tai Sin	54%	81%
	Yau Tsim Mong	27%	87%

Overall benefits

17. Overall speaking, the re-delineation exercise has brought benefits to patient services. Previously, patients in local communities might not be able to receive healthcare services in their residential vicinity in different stages of patient journey, e.g. patients from Wong Tai Sin district were usually transferred to KH for extended care; and vice versa, patients from Yau Tsim Mong district often received rehabilitation services in WTSH after receiving acute care in KWH. With the service network after the re-delineation, OLMH, WTSH, together with HKBH form a service network with QEH, while KH provides convalescent and rehabilitation services for patients transferred from KWH. As a result, continuity of care for patients in their residential vicinity throughout a patient journey, which is critical for chronic disease management, can be provided in hospitals under the same cluster. More effective vertical integration of care from acute phase to extended, primary and community after-care is achieved.

18. The re-delineation exercise is welcomed by both internal and external stakeholders. Internally, collaboration and teamwork among hospitals and service units in the new KCC have been established subsequent to the adaptation and change on workflow during the initial transition period. Engagement and communication with staff was carried out throughout the exercise. Externally, favourable feedback has been received from stakeholders. Before the re-delineation exercise, Wong Tai Sin district was served by two clusters. The Wong Tai Sin District Council has been demanding for more rationalised and better coordinated services in the region. After the re-delineation exercise, service provision for Wong Tai Sin district is now under the management of one cluster, i.e. KCC, and this has helped improve service networks with community partners, and enhance integration of care at medico-social level and appropriate transitional care. In addition to closer proximity, the patients are benefited from service synergy under a better rationalised service network of medical facilities and services within one cluster.

Demand and capacity evaluation

19. As part of the HA Action Plan for the cluster boundary re-delineation exercise, a capacity and demand gap analysis for all the seven clusters up to 2031 was conducted. The results of the analysis serve as a guide for facility planning and workforce building in clusters to facilitate provision of continuous care within or in the vicinity of the same geographical setting for patients, which also provide reference for future resource planning and allocation. The results of the analysis were reported to the Board in August 2016 for the Kowloon clusters, and in March 2017 for the Hong Kong and New Territories clusters.

⁵ Percentage distribution of inpatient discharges and deaths.

20. HA also completed in 2018 the latest demand-capacity analysis up to 2036. Having regard to the analyses, two blueprints of proposed capital works projects relating to hospital development and primary health care development are recently updated in order to meet the projected demands up to 2036 for inpatient and GOP services respectively. The aim is to facilitate the discussion between FHB and HA in identifying capital works projects for inclusion in the second 10-year HDP.

Catch-up improvement plan

21. HA has rolled out catch-up improvement plan in Kowloon East Cluster (KEC), New Territories East Cluster (NTEC) and New Territories West Cluster (NTWC) by mobilising the additional three-year funding of \$300 million, which was granted by the Government after the HA Review, to address known deficiencies in their service capacity. From 2015-16 to 2017-18, time-limited fundings were allocated to the three clusters to enhance their manpower, particularly for nursing, allied health and supporting staff.

22. Complemented by the funding support, additional beds were opened in KEC (36 beds), NTEC (71 beds) and NTWC (122 beds including 40 convalescent beds) in 2015-16. A total of 187 beds were opened in KEC (16 beds), NTEC (62 beds including 20 convalescent beds) and NTWC (109 beds including 75 convalescent beds) in 2016-17. For 2017-18, a total of 175 beds were opened in KEC (58 beds including 20 rehabilitation beds), NTEC (58 beds including 20 convalescent beds) and NTWC (59 beds including 30 convalescent beds) in phases. Capacity will be further enhanced in the three clusters through subsequent annual planning exercises.

Enhancing services in Wong Tai Sin District

23. For enhancing services in Wong Tai Sin district, resources were allocated to improve the provision of medical services for residents of Wong Tai Sin district over the past three years, including enhancement of computerized tomography service and orthopaedic service in OLMH. In 2015-16, additional manpower and resources were allocated to WTSH. Resources were also allocated to OLMH in 2015-16 to enhance its endoscopy service and day service. Besides, GOP service of OLMH has been augmented with the provision of service during public holidays. Refurbishment of HKBH is in progress with target completion by 3Q 2019.

Refine geographical boundaries for ambulance catchment area

24. Refinement of geographical boundaries for ambulance catchment areas amongst KCC, KEC and KWC was completed. Further periodic reviews with the Fire Services Department (FSD) will be conducted as and when required.

Recommendation 2 : Management and Organisation Structure

- (a) HA Head Office (HO) should **strengthen overall coordination on service provision to minimise inconsistencies among clusters** while exercising control over the development and introduction of highly specialised services and advanced technology to ensure well-coordinated development of services among clusters;
- (b) To ensure better division of labour, more effective support in cluster management, as well as better alignment of service provision at cluster level consistent with organisation goals, HA should –
 - (i) **re-examine the overall cluster management structure**, focusing on and streamlining the roles of the Cluster Chief Executive (CCE), Hospital Chief Executive (HCE), Coordinating Committee (COC) / Central Committee (CC), etc; and
 - (ii) **strengthen CCEs’ participation in the overall management of HA**, particularly on staffing, resources and services planning;
- (c) To enhance cooperation, coordination and role differentiation of hospitals within the cluster, HA should consider –
 - (i) where appropriate, **grouping two or more hospitals under the management of one HCE** to bring the scope of duties of all HCEs to a comparable level and to facilitate job rotation among HCEs; and
 - (ii) **delineating the role of individual hospitals** within a cluster so as to ensure the coordinated and planned development of all hospitals within the cluster and between clusters.

Highly specialised services

25. With the approval of the Board on 23 March 2017, HA has set up a new mechanism for introduction of highly specialised services (HSS), with emphasis on central coordination and training, to ensure consistency in service provision and adoption of new treatment and highly specialised technology among clusters. HSS are services that are structured to be provided in limited number of selected centres for concentration of expertise and cost efficiency, with service delivery organised through explicit referral networks. Some typical examples of HSS are transplant services and cardiothoracic surgery centres.

26. The mechanism for selection of centres for HSS involves two main stages, namely formulation of service development concept and application of the HSS mechanism for implementation of the concept, which will enhance central coordination in the provision and development of HSS. The mechanism provides consistent approach across COCs/CCs and among clusters/hospitals in the provision of HSS. The HA Directors’ Meeting (DM) will appoint a Proposal Assessment Group to play a key role in reviewing the programme

proposal. Through the mechanism, service networks and selection of centres will be better coordinated, and service development better aligned with corporate priorities and directions. Besides, comprehensive training plan is a pre-requisite of the programme proposal, thereby enhancing service sustainability and providing better training opportunity to the staff.

Role and responsibilities of CCEs

27. To achieve better division of labour and better alignment of service provision at cluster level with organization goals, the current roles and responsibilities of CCEs and their involvement and possible enhancements in the overall management of HA have been reviewed. In particular, CCEs' roles in the corporate management functions have been strengthened through job rotation and active involvement in corporate decision making and planning and budgetary processes. Meanwhile, CCE's role as a link person between the corporate and the cluster has been enhanced through early engagement in corporate policy development process beyond his role as a cluster head.

Regrouping of hospitals

28. With the support of the Board, we have regrouped the hospitals in various clusters to come under the steering of one HCE so as to enhance operational synergy whilst improving flexible deployment of resources across different hospitals in the cluster for the benefits of patients. The regrouped changes are summarised below:

HKEC ⁶	<ul style="list-style-type: none"> ● HCE of Pamela Youde Nethersole Eastern Hospital (PYNEH) to also head Wong Chuk Hang Hospital (WCHH) and St. John Hospital ● HCE of Ruttonjee & Tang Shiu Kin Hospitals, Tung Wah Eastern Hospital (TWEH) and Cheshire Home, Chung Hom Kok
HKWC ⁷	<ul style="list-style-type: none"> ● HCE of Tung Wah Hospital and Grantham Hospital (GH)
KCC	<ul style="list-style-type: none"> ● HCE of OLMH, WTSH and HKBH
KEC	<ul style="list-style-type: none"> ● HCE of Tseung Kwan O Hospital (TKOH) and Haven of Hope Hospital
NTEC	<ul style="list-style-type: none"> ● HCE of Shatin Hospital, Bradbury Hospice and Cheshire Home, Shatin
NTWC	<ul style="list-style-type: none"> ● HCE of Pok Oi Hospital (POH) and Tin Shui Wai Hospital (TSWH)

⁶ Hong Kong East Cluster

⁷ Hong Kong West Cluster

Through regrouping of the hospitals, solid HCE portfolios with sufficient and appropriate complexity as well as exposure are also developed to prepare HCEs for further career advancement. Job rotation between Chief Managers and HCEs are being arranged when opportunity arises.

29. With the Board's support, Deputy HCE(s) (DHCEs) are appointed where one HCE is managing two or more hospitals, so as to enable the HCE to have adequate time to address various management issues and to perform full HCE functions. To avoid unnecessary proliferation of management layers and prudent use of public money, creation of DHCE positions are subject to approval by the Central Staff Level Panel at HAHO, which is co-chaired by Director (Cluster Services) D(CS) and Head of Human Resources (HHR). DHCEs are identified through open invitations to colleagues working in the concerned hospitals. The selection board comprises CCE or his representative, Hospital Governing Committee (HGC) Chairman of the hospital or his representative, HCE of the hospital and a representative from HAHO. As at 31 August 2018, 14 DHCEs were appointed (excluding those DHCEs of the seven major acute hospitals). Similar to the DHCE arrangement for the seven major acute hospitals, an management responsibility allowance ranging from \$3,000 to \$5,000 will be granted to DHCE as a token of recognition to his/her taking up of the additional responsibilities.

Clinical Services Plan

30. HA targets to formulate a CSP for each cluster to map out its clinical strategies, intended service development and future service models, as well as role delineation of individual hospitals within the cluster. CSP is developed through a highly interactive and broad engagement process with clinical staff and senior management from across the cluster. Views from external stakeholders are also sought as appropriate. Extensive cluster-wide survey and department/specialty-based face-to-face interviews are held, followed by the formation of clinical work groups to develop proposals for major clinical programmes for the cluster that required cross-hospital, cross-specialty and multi-disciplinary collaborations. Through the CSP, the role of each hospital within a cluster is clearly delineated and services are aligned to meet local service needs. Inconsistencies in practice among hospitals and across clusters are minimised. So far, CSPs for five clusters have been completed⁸ and promulgated, namely HKWC, KEC, NTEC, KCC, and NTWC. Formulation of CSP for KWC has started since 3Q 2017 and is in good progress. The plan for HKEC will follow afterwards.

⁸ HKWC (March 2013), KEC (December 2014), NTEC (October 2015), KCC (December 2016) and NTWC (April 2017)

Recommendation 3 : Refined population-based resource allocation model

- (a) HA should **adopt a refined population-based resource allocation model** by reviewing the present approach and taking into consideration the demographics of the local and territory-wide population. The refined population-based model should take into account the organisation of the provision and development of tertiary and quaternary services, and hence the additional resources required by selected hospitals or clusters, as well as the demand generated from cross-cluster movement of patients; and
- (b) HA should develop the refined population-based resource allocation model and implement through its service planning and budget allocation process within a reasonable timeframe. To avoid unintentional and undesirable impact on the existing baseline services of individual clusters, HA should **consider appropriate ways to address the funding need of clusters** identified with additional resources requirement **under the new model, while maintaining the baseline funding to other clusters.**

Recommendation 4 : Resource bidding and allocation process

- (a) HA should work to improve and **simplify the procedures of bidding new resources by clusters** for new or improved services at the next resource allocation exercise (in 2016-17), with a view to streamlining and expediting the process and minimising the administrative workload of frontline clinical staff, balancing the need for efficiency and accountability; and
- (b) HA should enhance **transparency of the resource bidding and allocation processes** through better internal communication with clusters and within clusters on the methodologies, priorities and selection criteria. For the same reason, HA should explain the rationale and considerations behind the final decisions and allocation result starting with the next resource allocation exercise (in 2016-17) so that clusters can have a better understanding of how priorities are being determined and how resources are being allocated within the whole organisation.

The SC found that there was a **priority need for topping up funding for three clusters**, namely NTWC, NTEC and KEC, so that they can build up the capacity progressively now to serve the growing population demand in their catchment districts before the switch over to the proposed refined population-based funding model. The Government plans to allocate a **time-limited funding of \$300 million** for the next three years from 2015-16 to 2017-18 **to enhance the existing services of these three clusters** pending the implementation of the refined population-based funding model.

Refined Population-based Model (R3)

31. With the help of an external consultancy (The Jockey Club School of Public Health and Primary Care of The Chinese University of Hong Kong), HA has developed a Refined Population-based Model (Refined Model) to better inform resource allocation. Stakeholders at different levels of planning, budgeting, and execution (such as senior executives, clinical leaders as well as frontline staff, etc.) were engaged throughout the process of model building. Besides dedicated interviews and general consultation through cluster management meetings and hospital visits, an Interim Report was issued in October 2016 for wider stakeholder engagement. In regard to public interest, the project team communicated with external stakeholders including Legislative Council Members, media and patient groups. FHB was also updated regularly. The Final Report on the Refined Model was approved by the Board in September 2017. To enhance transparency, the Final report has been uploaded onto HA intranet and internet, and notification emails were sent to frontline and clinical stakeholders in HA.

32. The Refined Model⁹ has taken into account various factors that impact healthcare utilisation, e.g. population size, demographics, socioeconomic factors, chronic disease burden, distance from hospitals, supply; as well as the impact of 13 Designated Services¹⁰ and cross-cluster flow of patients¹¹ on individual clusters' resources. It aims to provide analytical tools to analyse and model population healthcare needs, and is not a direct funding formula.

Analysis under the Refined Model

33. The Refined Model enables analysis from multiple perspectives and time points to facilitate the understanding of Cluster resources and to identify the relative needs of Clusters in aligning with population development. Cluster resource analysis conducted using 2015-16 data revealed inter-Cluster variance to be within $\pm 0.5\%$, which means that under the existing service planning and budgeting mechanism, the overall Cluster expenditure generally corresponded to their respective scales of service provided. Capacity utilisation analysis would generate insight for capacity and facility planning to meet the needs of the local population in the longer term.

Implementation: Integrating the Refined Model into Service and Budget Planning

34. As emphasised in the HA Review, the Refined Model needs to be implemented through HA's service and budget allocation process while avoiding unintentional and undesirable impact on the existing baseline services of individual clusters. From the annual planning cycle for 2018/19, the analysis conducted under the Refined Model serves as one of the considerations to better inform HA's internal resource allocation (more details on the annual planning process is set out below).

⁹ The Refined Model was based on the utilisation data of six core services of HA (i.e. Acute Inpatient, Non-Acute Inpatient, Specialist Outpatient, Primary Care, Accident and Emergency and Allied Health Outpatient), which cover 96% of cluster recurrent expenditure.

¹⁰ Designated Services (DS) are specialised services that are only available in designated hospitals to serve the entire population of Hong Kong (e.g. liver transplantation services), and the scale of DS varies across Clusters.

¹¹ A cluster's provision of core services is not restricted to population residing in its vicinity as the public hospital system is not registration-based to restrict cross-cluster movement of patients.

Resource Bidding (R4)

35. The annual planning process is overseen by the HA Board, and the executive approval lies in the Service and Budget Planning Committee (SBPC), which is chaired by the Chief Executive of HA. The annual planning process seeks to deploy resources effectively, prioritise service provisions for the coming financial year, ensure a fair and transparent internal resources allocation system and monitor the implementation and progress of the approved programmes. Project proposal submissions by COCs/CCs, cluster management and divisions in HAHO will be discussed in the annual planning forums. Prioritisation of proposals in SBPC will normally take place in 2Q to ensure proper submission of Resource Allocation Exercise (RAE) bids to FHB. HA's strategic priorities and service directions, the programmes' operational readiness, and the Government's healthcare priorities are the key elements to consider in the prioritization process.

36. Transparency on the resource bidding and allocation process has been further enhanced after the HA Review. Staff are particularly appraised of the rationale and considerations behind the resource allocation decisions in annual planning forums. HA has also updated and promulgated the "Manual on Annual Planning", which outlines the structure and process of resource bidding in HA. Sharing sessions on the annual planning process were conducted among staff. Training workshops for frontline users to consolidate the workflow in the annual planning system were also arranged. Further, HA has enhanced the functionality of the Annual Planning System (APS), an automated system for service and budget planning in HA, through which data can be stored in a systematic manner to allow easy retrieval of past records and sharing of most updated reports simultaneously across different parties to facilitate communication.

Monitoring of the utilisation of the time-limited catch-up funding

37. HA closely monitors progress and utilisation of the time-limited catch-up funding of \$300 million for 2015-16 to 2017-18 to NTWC, NTEC and KEC as detailed in paragraphs 21 and 22 above. The three-year catch-up plans have been reviewed by SBPC and an additional recurrent budget has been allocated to the three clusters in 2018-19 to meet their recurrent financial requirements.

Recommendation 5 : Staff management

The SC considers that HAHO should enhance its coordinating role in staff management to ensure greater consistency, fairness and parity in human resources (HR) management across clusters. Internal communication on staff management issues should also be strengthened. In particular, the SC's recommendations on HA's staff management are as follows :-

- (a) While there is a need to draw a right balance between **central coordination** and decentralisation on matters relating to recruitment, promotion and deployment of staff to take into account the cluster-based organisational structure of HA, HAHO should enhance its coordinating role **to ensure greater consistency, fairness and parity in human resources management and practices in and between the clusters**. In particular, HA should exercise greater central coordination in the annual recruitment of Resident Trainees (RTs) and their placement to different specialties to promote a corporate identity and spirit;
- (b) Transparency in staff promotion and transfer processes should be enhanced through involvement of HAHO. HA should also **enhance transparency in promotion** with clear criteria and guidelines and well defined foci of representatives from HAHO and/or Hong Kong Academy of Medicine as appropriate;
- (c) HAHO should **strengthen its staff development programme** for senior managerial and clinical staff whereby senior staff will be given wider exposure **through different postings**. HA should also strengthen the rotation arrangement for trainees as part of their training programme;
- (d) HAHO should be able to assume the **central coordinating role of staff deployment** within the organisation when situation so warrants, such as in response to a large emergency situation, staff shortage or surge in service demand;
- (e) To address the needs of specific disciplines and maintain consistency in practices between hospitals, HA should **enhance the coordinating role of COC in different specialties**; and
- (f) **Regular communication** and reporting between clusters and HAHO should be established to **ensure common understanding on corporate personnel policies**.

In order to address the manpower shortage problem and encourage transfer of knowledge and experience, the Government will allocate to HA a **time-limited funding of \$570 million** for 2015-16 to 2017-18 to **re-employ suitable retirees** of those grades and disciplines which are facing a severe staff shortage problem, for a specific tenure period to be considered by HA.

38. Given the large size of its workforce and the decentralized organisational structure developed since its inception, HA recognises the need to align the HR practices and implementation of HR policies across clusters to ensure consistency, fairness and equity in staff management matters throughout HA. In the past three years, HA has implemented a series of initiatives to enhance the central coordinating role of HAHO, whilst retaining sufficient authority and autonomy at the cluster level; promote fair and equitable management practice; lessen the perception of sectarianism; and instil in staff the notion of being a member of the HA family rather than merely staff of individual cluster or hospital. The reinforcement of a collaborative culture has improved staff morale and engagement to support HA's service and development. The major initiatives include:

- (a) **Extending the established central system for monitoring creation and deletion of selected levels of senior positions in clusters / hospitals** to cover all key positions in cluster/hospital management with the role of head of department and function level, as well as posts or ranks new to HA for ensuring consistency across HA. Under the enhanced governance structure, deliberation in respect of HCE posts will need to go through the Central Staff Level Panel (the Panel) and DM before submission to EC for approval, while that for other posts will be conducted by the Panel with recommendation to DM for endorsement. The chairmanship of the Panel has been revised and is now co-chaired by HHR and D(CS), with two members from CCEs on rotation basis. Apart from creation of new posts, the Panel will also review application for deletion of senior posts to enhance consistency.
- (b) **Enriching the framework for HAHO representation in cluster selection boards by phases**, taking into account the readiness of the respective grades and specialties. Phase I, covering allied health, pharmacy, nursing and non-clinical grades, has been implemented in 1Q 2018. Phase II on central recruitment of associate consultants has been piloted in three smaller specialties of Anatomical Pathology, Cardio Thoracic Surgery, Medicine (Dermatology) of the Medical Grade in 2018/19 before rolling out to other specialties, taking into consideration complexity of involving multiple specialties with variations in their readiness to adopt central recruitment for associate consultants.
- (c) **Strengthening the alignment of HR practices and implementation of HR policies across clusters.** To ensure greater consistency, fairness and parity in HR management and practices across clusters, HA has strengthened the communication and partnership arrangement between HO and cluster HR departments in policy development and implementation. An HR Quality Assurance Programme was formulated to look into policies, guidelines, procedures and practices in selected disciplines of HR functions, with a view to identifying gaps and improvement areas. Quality assurance plan is drawn up by reviewing the HR management functions among the key foci of workforce management, training and development, staff wellbeing, and safe work environment. In 2017-18, quality assurance reviews were conducted on (a) exemption of pregnant staff from night shift duties, (b) Continuous Night Shift Scheme, and (c) Special Retired and Rehire Scheme (SRRS). HA will regularly review the rolling plan of quality assurance projects and make suitable adjustments, taking into account changes in organisational priority and service needs.

- (d) **Enhancing staff communication.** HA has mechanisms in place to enhance communication between cluster and corporate HR via the monthly HR Group meeting chaired by HHR with Cluster General Managers (HR), Chief and Senior Managers in HO HR Division as members. The HR Group discusses broad HR issues and macro HR challenges, as well as HR policies and measures. To ensure alignment of interpretation and practices, HR Forums are arranged to allow HR practitioners to share practices among colleagues. To further enhance staff communication and with the advancement of technology, HA has developed an HR App (HR mobile solution) to enable staff members obtain essential HR information via smartphones and other mobile devices in a timely manner. In addition, a “Staff Communication Guidebook” was developed to help HR professionals to better discharge their responsibility in staff communication.
- (e) Collecting staff views through **staff survey** is one of the strategies and directions under the area of “People Management” included in the HA Strategic Plan 2017-2022 and one of the key action items in response to the HA Review Recommendation on enhancing staff communication. An HA corporate-wide staff survey was conducted from 29 August to 3 October 2016. The survey questionnaire included 50 questions and two open-ended questions structured under four HA’s HR foci, namely Workforce Management, Staff Wellbeing, Training and Development and Safe Working Environment. Over 75 000 eligible staff members¹² were invited for participation. By the close of the survey period, 19 862 responses were collected, yielding a response rate of 26%. The survey revealed that the lowest scoring dimensions were “Communication” and “Respect & Recognition”. In addition, there was an apparent generation gap within the organization. Amongst the five staff groups, nursing and the non-care-related supporting staff groups were the two staff groups that indicated more areas of improvement. To follow up on the survey, a series of measures were taken at the corporate and hospital levels, including:

HA Overall

- Young Achiever Award to encourage and formally recognize the good performance of younger generation.
- Campus talk to early engage potential staff and build positive image of HA.

For Nursing grade

- Targeting on frontline Registered Nurses, Advanced Practice Nurses and junior Ward Managers, a pilot Executive Partnership Programme for Gen Y was launched in 3Q 2017. The Programme aims to build up a new stream of Executive Partners (Nursing) for training, better engagement and network building. It also creates a platform for the younger nursing generation to communicate with HAHO in a direct and transparent manner.

¹² Staff who have joined HA for three months and above before 30 May 2016 have been invited for participation.

- Inter-cluster study visits to promote local experience sharing among nurses at different levels.

For others non care-related supporting staff

- Enhance training and development opportunities for non care-related supporting staff such as developing grade specific training curriculum; reinforcing HA's appointment principle "to promote from within as far as practicable"; implementation of pay enhancement and progression model for staff, etc.

Besides implementing the above corporate action items, individual cluster management also implements cluster-specific action items such as providing training programme to facilitate cross-generation communication, organizing buddy/mentoring scheme to support new staff, enhancing and promoting staff recognition programme e.g. use of spot award and distribution of appreciation stickers to recognize staff's contribution, to address local improvement areas as appropriate.

- (f) **Formulating central staff deployment plan in emergency situations.** In order to enhance central coordination of staff deployment within HA during emergencies, HA has standardized the format and signatory of HA's appointment letter to emphasize the "one-HA" family culture and the authority for deployment by HA in case of need. In parallel, a structured approach is established to enable central coordination for activating staff deployment plan to cope with operation needs in emergency situations. The mechanism is stratified into two tiers. When emergencies arise, CCE shall manage the deployment of available resources at local level at the first place. If potential major service impact or interruption is anticipated, CCE shall escalate the issue to HO Grade Managers who will assess the impact and consider whether the situation warrants activation of central staff deployment by setting up a Task Group to formulate mitigation measures at corporate level. The Task Group will be led by the concerned Director and HHR at HAHO level and the concerned CCE, supported by members from relevant HO Grade Managers, COCs and the Head of the Department at cluster level.
- (g) **Enhancing rotation programme for staff.** HA has put in place measures to reinforce rotation of senior management and clinical staff to broaden their exposure and facilitate mutual understanding between staff and other clusters. A refined framework for job rotation arrangement was endorsed by EC in 2013 and 2014 for CCEs, Ds/Hs, HCEs and Chief Managers. With the successful experience of these target groups, the job rotation arrangement was further extended to Cluster General Managers and Senior Managers at Chief Executive Officer (CEO) rank in the Finance, HR and Hospital Administrator Grades in 2016.

HA supports professional development as well as exposure to facilitate service development and quality improvement. In regard to the recommendation that HAHO should strengthen the rotation arrangement for trainees as part of their training programmes for staff development, enhancements were made in the following aspects :

- (i) strengthening cluster-based intra-speciality and cross-specialty rotation arrangement by enhancing or setting up designated committees at cluster level to address both the training needs and service operations whilst ensuring opportunities are open up to RTs in different hospitals of the cluster and facilitating reporting to the central training governance;
- (ii) allocating centrally funded training posts to facilitate RT rotation, particularly for small specialties to address specialist training gap as well as to facilitate its rotation requirement; and
- (iii) implementing additional rotation requirements by COC (Ophthalmology) and COC (Clinical Oncology) as currently Ophthalmology and Clinical Oncology do not have mandatory rotation requirements under their specialist training curriculum.

With the implementation of the above framework, rotation arrangements for trainees are strengthened and continuous monitoring of RT rotation enabled, including implementation of cluster-based rotation arrangement with regular monitoring under training governance at both cluster and corporate levels. Moreover, additional rotation requirements in Ophthalmology and Clinical Oncology would also be piloted in 1Q 2019. Collaboration with the Hong Kong Academy of Medicine (HKAM) to enhance the rotation arrangement in specialist training curriculum of respective constituent Colleges would be continued.

Regarding the mechanism for training on new technology / services, HA has revisited the established mechanism for the safe introduction of new procedures/ technology (HAMSINP) to assure that the safety and efficacy of a new intervention or significant change is better than or equal to the existing practice before it is introduced into HA service. To ensure appropriate credentialing to keep up with the pace of technological change in HA, the subject team on credentialing has been formally engaged in all HAMSINP applications requiring full review starting from 2016. With this enhancement, clinical grades' recommendation on training could be provided through this channel. Arrangements have been reinforced for clinical staff outside the five hospitals where Robotic Assisted Surgery systems are installed, i.e. QEH, Queen Mary Hospital, PMH, Prince of Wales Hospital (PWH) and PYNEH, to obtain the training through the cross-cluster robotic-assisted surgical training scheme.

Progress is also achieved in the centrally coordinated simulation training. For example, exposures to new technologies such as Extracorporeal Membrane Oxygenation (ECMO) and opportunities to attend ECMO simulation training during staff rotation (currently only available in some Intensive Care Units (ICUs)) are facilitated by inter- and intra-cluster rotations. These rotations are enhanced through central coordination and monitored by the CC of ICU (COC(ICU)) and the designated committees on training and development set up at the cluster level. Furthermore, the multidisciplinary rotation scheme for Robotic Surgery is ongoing with satisfactory achievement of targets, and further consolidation of the mechanism is underway.

- (h) **Central recruitment of Resident Trainees.** To improve the annual recruitment exercise for RTs, 16 specialty-based Central Selection Panels were formed by all COCs to replace cluster-based selection interviews in 2016-17. All applicants were required to fix their specialty and hospital preferences (first and second specialty as well as a maximum of three hospital preferences for each specialty). After three rounds of centrally coordinated specialty-based interviews, a total of 363 RTs were recruited in the 2016-17 annual recruitment exercises for RT, with the number of RTs recruited in departments with acute manpower needs, e.g. Accident & Emergency (A&E) Departments and Obstetrics and Gynaecology Departments, increased from 35 and 13 in 2015-16 to 40 and 21 in 2016-17 respectively. Central recruitment of RTs continues, with 369 and 454 RTs recruited in 2017-18 and 2018-19 respectively. The service and manpower needs in respective specialties and clusters would continue to be monitored and addressed through the central coordinated RT allocation and recruitment exercise.

Special Retired and Rehire Scheme

39. HA has launched SRRS to help alleviate manpower issues and to retain suitable expertise for training and knowledge transfer. Supernumerary posts were created with additional Government funding for re-employment of retirees/retiring staff to the promotion ranks of medical, nursing and allied health grades under SRRS to ensure no promotion blockage to serving staff in the respective grades. For entry ranks of clinical posts and supporting grades posts, rehired retirees would fill existing vacancies. To ensure proper governance and management control, clusters are invited to submit requests for post creation for clinical grades under SRRS, taking into account service needs, potential supply of retirees and the potential supply of medical and nursing graduates. The Central Panel for SRRS chaired by HHR with D(CS), with members covering all CCEs or their representatives and the respective grade managers, will consider all the post requests.

40. The number of retired/retiring staff re-employed under SRRS in the past three years are summarized below:

Staff Group	No. of retired/retiring staff re-employed under the SRRS	
	2015-16 & 2016-17	2017-18
Doctors	61	28
Nurses	45	44
Allied Health Staff	8	5
Supporting Grades	787	1 024

41. Arrangements have also been made to streamline the appointment formalities such as pre-employment checks and waiving of probation requirement. Also, to better facilitate HA's manpower planning and individual staff's planning of re-employment after normal retirement, the centralised post creation and recruitment processes will start well in advance each year to enable offering of re-employment to the retiring staff recruited under SRRS around six months before the individual staff's last day of service.

Recommendation 6 : Staff training

- (a) HA plays a **key role in training and developing future generations of healthcare professionals** in Hong Kong. To ensure it performs this function effectively, HA should enhance its role in central planning and provision of training. More specifically, HA should set up a high-level central training committee under the HA Board to set overall training policy, allocate designated resources, and oversee implementation of the policy within HA; and
- (b) **Mechanism on selection of candidates for training** should be in place to enhance transparency and facilitate career development.

Separately, a **time-limited funding of \$300 million** for the next three years will be allocated to HA **for enhancing staff training** which includes strengthening of training support, especially for clinical staff, through scholarship, commissioned training programmes, staff rotation development programmes, simulation training courses and additional manpower support for training relief.

42. Staff training is pivotal to service provision, professional development and operation management. As recommended by the HA Review, HA has set up a dedicated committee under the Human Resources Committee (HRC) of the HA Board, entitled as the Central Training and Development Committee (CTDC), since 2015 to advise on policy issues relating to training and consider priorities of training initiatives and programmes. CTDC membership also includes, on top of Board Members, co-opted Members from the universities, HKAM and Civil Service Training and Development Institute. As at September 2018, 14 meetings were held by CTDC. At the second tier, the Training and Development Executive Group (TDEG), which is co-chaired by D(CS) and HHR, provides executive support to CTDC. As from October 2017, seven cluster representatives sit on TDEG to serve as a bridge between HA Head Office and clusters on staff training matters. At the cluster level, Clusters' Training and Development Committees were set up in 2018 to look after training-related matters which, in turn, would report to TDEG.

43. With the designated training fund of \$300 million provided to HA, CTDC had considered and endorsed a variety of training programmes from 2015-16 to 2017-18 to increase training opportunities, enhance quality and safety as well as improve job performance. A tracking mechanism was developed to monitor the fund utilisation, and progress reports were made to CTDC, HRC and the Board. CTDC is also monitoring the implementation progress of the key training initiatives under the HA Review Recommendations, including the development of training needs identification mechanism, grade-specific training curriculums, and training information management system.

44. HA has developed a structured mechanism for adoption by the seven clusters for identification of training needs to meet operational requirements. The mechanism was rolled out by phases in 2017-18. Grade-specific training curriculums for Finance, HR, Hospital Administrators and Information Technology (IT) grades have been finalised. The curriculums have been implemented in 2017-18 with regular review and fine-tunings by individual grades.

45. HA is enhancing its Training Information Management System (TIMS) to provide comprehensive and accurate training-related information for monitoring control and future planning. Phase I development, including users and system requirements formulation, prototype development and feasibility testing, was completed in 2016-17. In Phase II, the first stage of system development was completed and a number of selected training management reports at corporate level were ready by December 2017. With TIMS in place, senior executives can have an overview on HA training activities and resources to review training focus, ascertain public money spent prudently and address enquiries from different parties. Also, grade managers can monitor the progress of individual staff in the curriculum to ensure right training at the right time; and training organisers and/or COCs of different specialties can identify training gaps; and plan or adjust their training provision in terms of number and frequency to meet training demand. At the local level, cluster and hospital management can better understand the training status of their staff members and benchmark across clusters; and finally individual staff is able to easily keep track of their own learning progress.

46. Under the steering and direction of CTDC, the additional \$300 million designated training fund from the Government enables HA to organise new training programmes, scale up or continue existing time-limited training programmes to further support service development, enhance staff's professional development, and meet the job and operational needs. Enhancement in both local and overseas training opportunities for clinical staff is made through increasing the quotas of corporate scholarship and central commissioning programmes, scaling up the simulation training and basic resuscitation training, improving the training support for interns and enhancing training support to small specialties such as Immunology, Anatomical Pathology, Cardiothoracic Surgery. The fund also supported the nursing preceptorship programme by recruiting increased number of nurse preceptors to enhance the proficiency of junior nurses.

47. Also, the training opportunities for non-clinical staff were improved through local and overseas conferences / courses, including respective Continuing Professional Development programmes of legal and finance professionals. Training programmes on Healthcare Service Management Training (HSMT)¹³, mediation skills, people management and teamwork skills, workplace violence, psychosocial support services were also promoted to enhance critical business knowledge for clinical leaders / executives and equip frontline staff with the necessary skills in communicating with patients. There are also increasing rotation and attachment opportunities for corporate communication and finance professionals to expand their management exposure.

48. In order to facilitate a longer term and more coordinated planning of staff training in HA, and taking into account the projected annual growth of 3% in staff population in the coming five years, additional recurrent funding has been sought to address unmet training needs in HA in support of service development, professional development and job/operation requirements. CTDC will continue to consider the priority areas and related training programmes of HA.

49. Separately, HA is also conducting active discussions with external professional bodies and universities to strengthen current collaboration platforms for enhancing training capacity and capability. In this respect, the Medical, Nursing, Allied Health and Pharmacy Grades have each established formal liaison platforms/forums with external training partners in 2016. For doctors, HA and HKAM have met four times since the setup of the collaboration platform in 2016. Both parties have agreed on the priority areas and the respective action plans on the facilitation of HKAM Constituent College examinations in HA hospitals and simulation training collaboration between HA and HKAM. Additionally, HA now plans to utilize the platform to obtain HKAM's input on trainee allocations. Nursing, Allied Health and Pharmacy Grades are working with local tertiary education institutions, and the potential areas of collaborations span from undergraduate programme curriculum and clinical placement to postgraduate programmes collaboration. Development of staff appointment mechanism between academic institutions and HA is on-going to help further build up training capability of all parties, as well as research capabilities among HA staff and conduction of healthcare operational and clinical research.

13 With its substantial business knowledge and experience accumulated in healthcare service management, HA since 2015-16 has developed and established the HSMT curriculum as executive training for clinical managers / leaders and executives. A total of 52 e-modules was fully developed and launched in March 2018.

Recommendation 7 : Key Performance Indicators (KPIs)

- (a)** The HA Board, being a managing board, should play a more active role in setting key standards and targets to:
 - (i) monitor the overall performance and service provision for public accountability; and
 - (ii) facilitate management decision to improve performance and drive best practices; and
- (b)** HA should enhance and refine the KPIs in 2015 to better address service demand and management, facilitate service planning and resource allocation, and drive best practices amongst various specialties, hospitals and clusters.

50. HA's KPI framework comprises the three pillars of clinical services, HR and finance, and HA conducts annual KPI review to ensure that the KPIs in force are robust enough to reflect service performance to cater for current service needs, and in line with the service directions and priorities of HA. Through performance monitoring and benchmarking, KPIs help flag up issues for special attention and identifies areas for service improvement, as well as drive best practices among clusters to help develop efficient models of operation. HA can also ascertain service gaps between capacity and demand through capacity KPIs, thereby providing direction for capacity building and resource allocation. The KPIs are reported to and reviewed by individual functional committees of the HA Board at regular intervals, while quarterly KPI reports are submitted to the Board for overview.

51. Arising from the HA Review, new KPIs to reflect capacity-demand gap and service efficiency on key pressure areas, including access to Specialist Outpatient (SOP) and Operating Theatre (OT) services and the access block problem, were endorsed by the Board in February 2016 for phased implementation in 2016-17. For SOP services, indicators were developed to reflect efficiency in allocation of medical manpower for new and follow-up cases and the capacity gap in managing the waiting list for new case demand. On OT services, indicators were developed to reflect the serving capacity of the existing OT facilities for elective surgeries and give insight into the potential areas for further optimising and maximising the utilisation of OT resources. On access block monitoring, an indicator was developed to reflect the frequency and magnitude of the access block problem and the service impact resulting from improvement measures taken.

52. To mitigate the risks arising from service capacity constraints, HA has implemented a basket of measures to address the situations. Further details on waiting time management of SOPC and A&E services are set out under the response plan to recommendation 8(a) below.

53. HA has also developed an information system (HA Management Information System, “HAMIS”) comprising different functional modules for phased implementation from March 2018 to facilitate reporting, performance monitoring and improve dissemination of KPI information to different levels of staff, which in turn drives organisation learning and facilitate sharing of best practices.

Recommendation 8 : Waiting time management

- (a) HA should implement a comprehensive plan to shorten waiting time for SOP Clinics (SOPC) and A&E services with a view to enabling timely access to medical services and minimising cross-cluster variance in waiting time.

54. Waiting time in SOPC and A&E service is essentially the result of demand and capacity imbalance, given that healthcare demand is escalating due to Hong Kong’s ageing population and rising prevalence of chronic illnesses. Medical manpower shortage remains a crucial factor that limits service capacity. In some hospitals, the lack of physical space for clinic expansion is also a factor contributing to the existing waiting time problems in HA services. As a result, the waiting time for patients, in particular those with less severe and non-urgent conditions, have lengthened over the years. A basket of measures was formulated to address the waiting time issue.

SOPC waiting time management

55. For SOPC, urgent conditions requiring early intervention and categorised as Priority 1 (urgent) and Priority 2 (semi-urgent) are handled within the designated time limits¹⁴. However, the waiting time for new booking of routine (stable) cases in some SOPC has lengthened considerably. Against the ever rising demand, HA is striving to help relieve the long waiting time. Specifically, we have refined the service model for the high pressure areas of Orthopaedics & Traumatology (O&T) by diverting suitable routine cases to Family Medicine Specialist Clinics (FMSC). Further extension/customisation of the model to other appropriate specialties will be explored for relieving SOPC workload under pressure. In regard to mental health services, the multidisciplinary teams are enhanced to cope with the rapid increase of demand. Multi-pronged strategies are also deployed, such as undertaking conversion works to increase consultation rooms to improve the capacity and efficiency of SOPC services. Efforts are made to align practices of different clusters, minimise cross-cluster variance in waiting time and facilitate patients to make informed decisions for pursuing cross-cluster treatment. Further details of the key action items are set out in paragraphs 56 to 64 below.

¹⁴ HA’s performance target is to keep the median waiting time for Priority 1 and 2 new cases within 2 and 8 weeks respectively.

Key Action 1 : Utilise FMSC to relieve pressure on O&T SOPC service

56. In October 2017, KEC and NTEC commenced the 2017-18 annual plan proposal on using FMSC to attend O&T routine new SOPC cases. The arrangement is protocol driven, and cases for diversion to FMSC are mainly patients suffering from back problems which are of low risk nature and do not involve surgical intervention but only functional rehabilitation. A rough estimate is around 20% to 30% of low back pain cases may be transferrable to FMSC for consultation.

Key Action 2 : Employ new multi-disciplinary strategy to relieve pressure on psychiatric SOPC service

57. HA has enhanced the multidisciplinary teams to cope with the rapid increase of service demand for mental health services. The use of trained psychiatric nurses and allied health professionals under supervision of doctors is proved to be effective in improving treatment outcome, and the development of criteria for closing cases also helps discharge those who have satisfactorily completed the care plan developed by doctors. This service delivery model enables the availability of more doctor consultation sessions for new cases with a view to shortening the SOPC waiting time. Taking KWC as an example, with the enhancement of their multi-disciplinary teams, the 90th percentile waiting time of patients booking new cases at the adult psychiatric SOPCs triaged into routine cases in KWC was reduced from 61 weeks in June 2015 (before the enhancement) to 43 weeks in July 2018.

58. Since 2015-16, HA has enhanced the multidisciplinary teams of psychiatric SOPCs in KWC, KEC, NTEC and NTWC for patients with common mental disorder (CMD) by phases. Also, with the implementation of the enhanced SOP service for patients with CMD, the pilot on corporate-coordinated cross-cluster booking for suitable patients with CMD has also commenced in KWC, KEC, NTEC and NTWC. Up to 31 July 2018, a total of 856 cross-cluster referrals had been received.

Key Action 3 : Manage SOPC referrals

59. Arrangements have been made to facilitate the triage process and improve the quality of referrals, by refining the structured disease templates on back pain and neck pain in the electronic referral system with specific reference to the established clinical guidelines and protocols. The refined templates have been rolled out in May 2016. A review was conducted after the rollout and the feedbacks were positive, reflecting improved quality of referrals, facilitated triage process and improved efficiency of triage.

Key Action 4 : Employ multi-pronged strategies to generally improve SOPC capacity and efficiency

60. Works to expand physical capacity for SOPC service are progressing in on-going projects and projects under planning, including redevelopment of KWH, Kwai Chung Hospital (KCH) and OLMH; expansion of United Christian Hospital and North District Hospital (NDH); and NAH at KTDA. Yaumatei SOPC has been reprovisioned in the Ambulatory Care Centre (Extension) / Block T at QEH. SOPC services in the new TSWH have commenced on 9 January 2017. HA has also been taking active steps to engage collaboration with the private sector to deliver public healthcare services via strengthening primary care, including the territory-wide implementation of the GOPC PPP Programme,

which was fully extended to all 18 districts in April 2018.

Integrated Model of Specialist Outpatient Service through Nurse Clinics

61. At present, outpatients will be referred by doctors to nurse clinics or allied health clinics after medical consultation based on patients' clinical needs. HA has explored a new service delivery model in outpatient setting to manage and coordinate outpatient services more effectively and efficiently. The Integrated Model of SOP service seeks to develop a cohesive pathway in delivering care in SOP setting. The philosophy is to provide outpatients with the right care by the right person at the right time. It is a patient-centred approach focusing on the needs of individual in the continuum of specialist care, and puts emphasis on access and effective intervention of problems in a timely manner. With better role delineation, it is expected that the resources of SOP clinics can be optimised when each profession can focus on their expertise.

62. Under the Integrated Model, the clinical pathway is pre-defined with clear criteria for each new case intake, follow-up and discharge process. The care provided for patients requiring specialist service will be guided by the clinical pathway, which also determines the selection of attending professionals throughout the process. It can be a nurse, a doctor or an allied health professional. The Integrated Model is being piloted in four specialties / sub-specialties, namely Clinical Oncology, Urology, Rheumatology and Peri-Operative through nurse clinic in 2018-19, and will be evaluated at 1Q 2019. Operational issues and outcomes of the implementation will be examined, with particular focus on the efficiency of service delivery; service quality and risk management; waiting time management and data capturing. The outcome and experience of the pilot from the perspective of healthcare professionals as well as from that of patients will also be consolidated and evaluated. Once the direction of implementing this Integrated Model in SOP service is confirmed, stakeholders will be engaged to fine-tune the operation details.

Key Action 5 : Align practices of different clusters and minimise cross-cluster variance in waiting time

63. The SOPC Phone Enquiry Systems, aiming to answer patient enquiries and enhance utilisation of SOPC quotas by facilitating rescheduling and cancellation of appointments, were implemented in all seven clusters by 2015-16. In 2016-17, the programme was extended to six other hospitals, including Hong Kong Eye Hospital, TKOH, CMC, KWH, YCH and Alice Ho Miu Ling Nethersole Hospital (AHNH). In 2017-18, the programme was further rolled out to six more hospitals, including the Ruttonjee Hospital, TWEH, GH, KCH, NDH and Castle Peak Hospital. The plan was completed with more than 100 000 attendances a year.

64. HA has launched a Mobile Booking Apps "BookHA" since 8 March 2016 to provide patients of major specialties, including Gynaecology, Ear, Nose and Throat, Neurosurgery, Ophthalmology, O&T, Cardiothoracic Surgery, Medicine, Surgery, Obstetrics and Paediatrics, with a more convenient means of making SOPC new case booking, apart from coming to clinics in person or sending in application by facsimile. Up till end of June 2018, the total app downloads exceeded 255 000 times and booking requests submitted via BookHA exceeded 125 000 times.

A&E waiting time management

65. For A&E waiting time, patients with critical and emergency medical condition are receiving timely medical treatment. On the other hand, waiting time for patients with less severe conditions (Category III) has lengthened, in particular during peak utilisation seasons. To manage the A&E service, HA has put in place various measures to ensure that A&E patients with pressing medical needs can receive timely medical treatment, and to improve the waiting time of Category IV and Category V patients in A&E departments. HA has implemented “Rapid Assessment and Treatment Model” in QEH and tried out the model in PWH, re-engineering the work process to allow early assessment of Category III patients by a specific team led by a senior doctor to make initial assessment and define the care plan.

66. HA will continue to closely monitor the manpower situation in A&E department and make appropriate arrangements in light of service needs and operational requirements. In 2018-19, HA recruited 39 RTs and 37 nurses (up to 31 August 2018) to A&E departments for replacement of attrition and support of new services. At the same time, HA has also expanded the scale and coverage of the A&E Support Session Programme. The Programme recruits additional medical and nursing staff (including those from non-A&E departments) to manage Categories IV and V cases, thus allowing doctors and nurses to focus their effort on the more urgent cases. In 2017-18, A&E departments had operated support sessions at a total of around 17 500 hours, equivalent to around 4 400 four-hour sessions. The Programme continued to be implemented in 2018-19, and was extended to A&E department of TSWH. Subject to availability of resources, HA plans to continue the Programme in 2019-20.

67. HA has also developed a transparent mechanism and an open platform for releasing information on estimated waiting time of the different A&E departments to the general public. HA has standardised the waiting time information of A&E departments since 20 December 2016. Information is released to the public via the HA website, smartphone Apps (HA Touch) and enlarged television displays at the registration counter of A&E departments. The waiting time information could be a reference to facilitate patients with minor ailment to understand the overall service situation before attending A&E departments. In addition, the Primary Care Directory managed by the Department of Health (DH) and its link to the Directory online are also available in A&E departments for patients with minor ailment to consider using private outpatient services. Furthermore, hospital management could access real-time A&E queueing information via management dashboard.

68. Addressing the problems of long waiting time in SOPC and A&E is a priority for HA. HA will continue to monitor the demand for services and raise the capacity of its priority services, particularly for high demand services having regard to the projected demand arising from a growing and ageing population, and roll out service enhancements within the resource constraints. The Board and its functional committee will continue to keep a close eye on the related services.

Recommendation 8 (b) : Access block

(b) *HA should coordinate with relevant specialties to address the serious access block problem in A&E Departments in concerned hospitals.*

69. The access block problem is a result of issues in service capacity with shortage of bed and manpower resources, which require considerable lead time to fill the capacity gap through annual planning and resources allocation exercises. HAHO has been working jointly with KCC and NTEC, the two clusters with particularly noticeable access block problem, and provided inputs and support to cluster strategies from both policy and resource aspects. Besides, HAHO has developed the Hospital Bed Management Dashboard to facilitate better coordination for acute and convalescent beds. For short and medium terms, both KCC and NTEC have strengthened intra-cluster bed coordination to facilitate patient flow for more efficient use of beds among hospitals in the clusters. At the same time, HA will continue building up the service capacity of both clusters by opening additional beds by phases through annual planning exercises. A KPI has also been developed to continue monitor the situation and to reflect the progress of the improvement measures being taken. Observation on access block situation will be continued through regular KPI monitoring.

70. The major direction for KCC in addressing the access block problem is to improve bed usage and facilitate patient flow through better coordination of cluster hospitals. With OLMH and WTSH joining KCC after the cluster boundary re-delineation exercise, a more flexible use of convalescent beds in the cluster is enabled to facilitate patient flow through a service network of the partnering hospitals. QEH has formed a service network with HKBH, OLMH and WTSH, which would streamline and coordinate the patient pathways from acute to non-acute hospitals, while KH will provide convalescent and rehabilitation services for patients transferred from KWH. Bed capacity building is being planned under the hospital redevelopment projects and through annual planning exercises. As for NTEC, the major issue is its capacity in view of high bed occupancy rate of the hospitals in the cluster. To alleviate its access block problem, NTEC strives to build up its capacity by opening more beds. In 2017-18 Annual Plan, 20 Surgery acute beds and six Medicine day beds in PWH, 12 Orthopaedics acute beds in AHNH and 20 Medicine convalescent beds in NDH were opened. In 2018-19, a total of 125 beds including 105 acute beds and 20 convalescent beds will be opened in NTEC. Bed capacity in both clusters is planned to be further enhanced by phases through the HA annual planning exercises.

71. On demand management, KCC and NTEC have also implemented a series of measures to enhance discharge management and reduce unnecessary A&E attendances. Examples are provision of onsite geriatric assessment in the Emergency Medicine Ward and AED of QEH for emergency elderly patients, increased weekend and evening ward rounds, setting up and expanding the discharge lounge for Medicine discharge patients (in association with enhancement of Non-Emergency Ambulance Transfer Service (NEATS) services), and strengthening the 'Sunshine Team' to support portering, cleansing, discharge and medication delivery.

Recommendations 9 :

- (a) HA should enhance its **service capacity** and review its service **delivery model** to better prepare itself to meet the **challenges of the ageing population**;
- (b) Specifically, HA should enhance **step-down care, strengthen ambulatory services,** and enhance **partnership with non-governmental organisations** and the **private sector** with a view to providing comprehensive healthcare and support for patients, in particular elderly patients;
- (c) HA should actively **work with the Department of Health and the welfare sector** on healthcare services to promote and enhance primary care and rehabilitation services in non-hospital setting. The objective of this new model of care is not only to make better use of the resources but also to address the needs and provide better care for patients, in particular elderly patients, in an ageing society; and
- (d) HA should ensure an effective mechanism is in place to take into account **patients' feedback** for service planning and improvement.

72. Ageing population and rising incidence of chronic disease are two key challenges faced by HA. To guide the development and delivery of healthcare services for older persons through a systematic approach, a Strategic Service Framework for Elderly Patients was formulated. Strategies are put in place for providing appropriate level of care based on the stratified risk and needs of individual patients. To keep pace with the anticipated growing demand arising from an ageing population and to better manage elderly patients with chronic illness in the community, HA will continue to increase service capacity; review and develop service delivery models and strengthen partnership with community partners; and strengthen patient empowerment and engagement.

Increase service capacity

73. HA continues to raise its capacity in priority services, particularly for high demand services having regard to the projected demand arising from a growing and ageing population, and roll out service enhancements within the resource constraints. In 2015-16 and 2016-17, 250 and 231 hospital beds were opened respectively. In 2017-18, HA opened 229 additional beds to meet the growing demand arising from population growth and ageing. In 2018-19, HA plans to open 574 beds. HA will continue to commission services in TSWH and North Lantau Hospital (Phase 1) in phases. HA will also make preparation for the commencement of services in Hong Kong Children's Hospital in phases, starting with SOP services for Nephrology and Oncology in December 2018, followed by the gradual commissioning of inpatient services in 2019.

74. As announced in the 2016 Policy Address that \$200 billion would be put into implementing the first 10-year HDP, implementation of the HDP is now in full swing, including the following major capital projects for providing capacity for a total of more than 5 000 additional beds and three new Community Health Centres:

- construction of a NAH in the KTDA;
- redevelopment/expansion of existing 11 hospitals;
- construction of three new Community Health Centres; and
- construction of a new Supporting Services Centre.

75. In parallel with the implementation of projects under the first 10-year HDP, the Government has invited HA to commence planning for the second 10-year HDP. A total of 19 projects involving about \$270 billion will be covered. Upon completion of the whole plan, there will be over 9 000 additional beds and other additional hospital facilities that will largely meet the projected service demand up to 2036.

76. HA is also striving to strengthen its GOP services to meet the increasing service demand. With the implementation of various measures, HA has increased the number of GOP attendances by a total of over 600 000 attendances from 2012-13 to 2017-18, including those of the evening and public holiday out-patient services. GOPC quotas in various clusters were increased by 55 000 (77 000 Full Year Effect) in 2015-16, 27 000 (49 000 Full Year Effect) in 2016-17, and 27 500 (44 000 Full Year Effect) in 2017-18. To cater for the demand for GOP services, HA plans to increase gradually the GOPC consultation quotas by more than 99 000 attendances in 2018-19 and 2019-20. HA has strengthened its support to frail elderly patients living in Residential Care Homes for the Elderly (RCHEs) by Community Geriatric Assessment Team (CGAT). As at 31 March 2017, around 670 RCHEs (more than 90%) were covered by CGATs.

PPP Programmes

77. Introduction of clinical PPP programmes helps provide choices to patients, enhances patients' access to clinical services and helps HA manage the related demands. HA has launched a variety of clinical PPP programmes over the years, with encouraging responses gained from patients, healthcare professionals and the community at large. The GOPC PPP programme was successfully extended to all 18 districts with the roll-out completed in April 2018. As at the end of June 2018, over 360 Participating Service Providers were providing consultation services to more than 24 000 GOPC patients who have joined the Programme. The territory-wide implementation will give patients more choices in selecting their family doctors all over Hong Kong.

78. Annual investment returns generated from the HA PPP Fund – the \$10 billion endowment set up by the Government since 2016 – is a sustainable source of funding for assuring the continuation of existing clinical PPP programmes at current scope and supporting their further development in long term at a broadened scope or a widened coverage as well as developing new clinical PPP initiatives in future. HA will continue to expand healthcare service and widen choices for our patients through collaboration with the private sector.

79. As another new initiative, a new PPP Programme (Glaucoma PPP) is being introduced for eligible glaucoma patients in HA to receive specialist care in the community. All private ophthalmologists registered as Specialists in Ophthalmology under the Medical Council of Hong Kong will be invited to enrol in the Programme as Participating Service Providers. The target group of Glaucoma PPP is HA's existing patients with glaucoma who are clinically stable and have been followed up at HA ophthalmology specialist outpatient clinics for at least one year. The pilot Programme is scheduled to be launched in 2Q 2019.

Review and develop service delivery models and strengthen partnership with community partners

80. In recent years, HA has strengthened its palliative care service in different areas. For instance, HA has developed palliative care service models for patients with end-stage organ failure, especially patients with renal failure, working in collaboration with other specialties. Palliative care day centres are developed through collaboration with community partners to provide one-stop multidisciplinary care for patients living in the community. Psycho-social support and bereavement care have also been enhanced by strengthening the services of medical social workers and clinical psychologists.

81. To support terminally-ill patients living in RCHEs, HA's CGATs are working closely with the palliative care teams as well as RCHE staff to strengthen the care of RCHE patients at end-of-life stage, and to provide relevant training to RCHE staff.

82. To plan and further improve the quality and sustainability of HA's palliative care service as well as to cope with increasing demand, HA has developed, in 2017, the "Strategic Service Framework for Palliative Care" (the Framework), to guide the development of palliative care service in the coming five to 10 years. Strategic directions for improving adult and paediatric palliative care were formulated. Regarding palliative care training for different healthcare disciplines in HA, HA would continue to work on the initiative to further enhance the competency of nursing staff supporting terminally ill patients beyond palliative care setting through structured palliative care clinical attachment and skill transfer programme in 2018-19.

83. HA all along provides General Infirmery Services in hospital settings. To enhance the choices of infirmery care services for applicants on the Central Infirmery Waiting List, HA has developed a service model that involves partnership with non-governmental organisation (NGO). To pilot a PPP model for the provision of infirmery services, HA has contracted with Po Leung Kuk to operate infirmery services at the WCHH with a maximum capacity of 64 beds for three years. Po Leung Kuk commenced the services in 2016.

84. HA has been exploring practicable ways to alleviate the anticipated overburdened hospital services and to facilitate "ageing in place". To this end, HA is working with POH Board of Directors to develop a collaborative service model for a large-scale RCHE in Lam Tei near Tuen Mun Hospital (TMH). The new model of service is intended to enhance the quality of care, avoid causing physical and psychological burden to the elderly residents due to transfer between RCHE and hospital, and prevent risk of contact with infections in hospital. The service of the RCHE is planned to commence in phases upon its completion of construction in 2021-22 the earliest.

85. Through a systematic approach to cope with the anticipated growing demand due to an ageing population, HA strives to achieve that elderly patients are managed at appropriate levels of care with better control of health, retardation of disease progression, staying in the community with improved quality of life and reduction in avoidable hospitalisation. HA has developed the Community Health Call Centre services to provide telephone advice and support to diabetes mellitus patients in Medical SOPCs on disease management. HA has also put in place enhanced services in collaboration with DH to provide influenza vaccination to patients with chronic disease and elderly living in the community. HA clinics continue to provide vaccines to eligible target groups till the exhaustion of stock to enhance vaccination rate among target groups.

Strengthen patient empowerment and engagement

86. HA continues to strengthen patient empowerment and engagement, e.g. through Patient Empowerment Programme, Patient Experience Survey (PES) (formerly known as Patient Experience and Satisfaction Survey), strengthen patients' participation in committees and enhance the roles of Patient Resource Centres (PRCs).

87. Understanding patient experience is a key feature of quality improvement in modern healthcare delivery. Following the international trend, HA has been using PES to proactively collect patients' feedback for quality improvement. PES is generally well received by staff, patient groups and the public. HA will continue to implement corporate PES to collect patients' feedback on HA services. Since 2015-16, the following PESs were conducted.

2015-16	PES on Inpatient Service
2016-17	PES on Accident & Emergency Service
2017-18	PES on Inpatient Service

The PES findings have given an overview of HA's inpatient service and highlighted areas for quality improvement. In response to the PES Reports, HA will continue to study and analyse the survey results, develop plans and prioritise areas for quality improvement. Taking the relatively lower rating in the provision of discharge information reflected by the 2015 PES on Inpatient Service as an example, HA has launched a pilot project in individual public hospitals to provide discharged patients with a summary sheet with salient medication reminders and future medical appointments. Subject to review of the pilot experience and outcome, HA aims to extend the project to other public hospitals in due course.

88. PRCs serve as hospital focal points in engaging the community, in particular patient groups, volunteers and NGOs, and liaising with patients and carers for enhancing support during the process of care. As the majority of our chronic patients are staying in the community, PRC is playing an important role in helping patients form support networks as well as in nurturing their abilities to help themselves and the others. Typical services of PRCs involve patient empowerment and support, support to patient groups, volunteer service development together with community engagement and partnership. Via different platforms of stakeholder engagement, strategic directions and priority actions were formulated to guide further development of PRCs. The key developments focused on improvement in the areas of governance, integration to care pathways, alignment with corporate service foci, volunteer service development and the development of infrastructure

and enablers for enhancing PRC services. With collaborative efforts, HA has over the years built up an extensive network with patients / patient groups, volunteers, NGOs and other community partners. With PRCs' role as a bridge for interfacing hospital care with the community enhanced, it is envisaged that partnership on patient empowerment and support could be further strengthened as an integral part of the care process. HA will further develop programmes and initiatives in accordance with the strategic directions and priority actions identified for PRCs, as well as to monitor and review the development and implementation of the initiatives involved.

89. A New Smart Elders platform with enhancement on carer information on Smart Patient Website was launched on 1 March 2016. The service model and contractual partnership with NGOs on the Patient Empowerment Programme to support patients with diabetes mellitus or hypertension was reviewed. The enhanced model under new service contract has been implemented since April 2016 with more emphasis on personalization.

90. To enhance patients' understanding of HA services and facilitate their engagement at various levels in hospitals and HAHO, HA has been organising a structured training programme, entitled Patient Partnership in Action, for patient leaders nominated through the Hong Kong Alliance of Patients' Organizations and cluster hospitals since 2015-16. A total of 80 leaders had completed the programme in the past three years. Further training to patient leaders will be arranged through the Patient Partnership in Action programme on an on-going basis. We will continue to appoint patient representatives to HGCs when opportunity arises to gauge their views on hospital operations and seek for continuous improvements.

91. With on-going initiatives for the increase in HA's service capacity, closer collaboration with community partners as well as strengthening of patient empowerment and engagement, HA strives to make better use of the resources to ease the burden of public hospital services, to provide more comprehensive healthcare to elderly patients, and to aid continuous service improvement.

Recommendation 10 – Safety and quality of services

- (a) HA should strengthen the **roles of COCs on clinical governance**, including the development of clinical practice guidelines, services standards, introduction of new technology and service development plan for its respective specialty to achieve more standardised service quality and treatment and to ensure safety;
- (b) HA should review the **role of Chief of Service (COS)** with greater emphasis in clinical governance;
- (c) HA should review the **inter-relationship of COC/CC** and various services committees with a view to streamlining internal consultation on **annual resource planning** and clinical service development. HA should address the concerns of frontline clinical staff and review their administrative workload to ensure they can concentrate and focus on their core duty of providing care for the patients;
- (d) HA should, through COCs, develop a system of **credentialing** and defining scope of practices to ascertain professional competence and to ensure patient safety;
- (e) HA should step up the implementation of **clinical outcome audits** as a tool to assess and monitor clinical competence and service outcome for seeking service quality improvement; and
- (f) In examining the root cause for the occurrence of a **medical incident**, HA should strengthen the sharing of lessons learnt among clusters to minimise the possibility of its recurrence, and consider measures to enhance communication with and support for patients.

Strengthen the roles of COCs on clinical governance

92. HA places quality and safety as top priorities in the planning and running of its services, by establishing governance structure and systems to ensure high clinical standards. HA has enhanced the roles and responsibilities of COCs in clinical governance, specifically in setting service standards, developing clinical practice guidelines, education and training, conducting clinical audits, managing clinical risk management and introduction of new technology and service development. A standardised set of Terms of Reference was promulgated to COCs in August 2016. COCs are required to include the following standing agenda items in COC meetings from 1Q 2017:

- (a) Standard of clinical service and care;
- (b) Workforce and training;
- (c) Quality and safety; and
- (d) Technology, therapeutics and information technology.

Through the concerted efforts of COCs, clinical governance in HA is strengthened to upkeep the quality and clinical standards of services.

Enhance the role of COS with greater emphasis on clinical governance

93. HA has engaged COSs and doctor groups on the enhanced role of COS, particularly in quality of patient care and patient safety. COSs and senior doctors are encouraged to complete the Quality and Safety modules in Healthcare Service Management Training e-Course (which provides concise learning information on an array of quality and safety subject matters such as accreditation; clinical incident management) which was released in 2Q 2016.

94. HA has specified the management functions of COS as related to clinical governance in the COS appointment and staff appraisal procedures. Management functions related to clinical governance are specified in the job description and key responsibilities in Vacancy Notification Circular for COS. This enhancement and the emphasis of the COS's role on clinical governance were communicated to CCEs/HCEs, Cluster HR and COCs.

Develop a system of credentialing and defining scope of clinical practices

95. Credentialing refers to the formal process used to verify the qualifications, professional training, clinical experience and other relevant professional attributes of healthcare professionals for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organizational environments. The principles of credentialing are to enhance patient safety and to confer public confidence in HA services.

96. HA actively pursues the development of a system of credentialing and defining scope of clinical practices. The first batch of five high risk and complicated procedures from three specialties were endorsed as HA credentialing activities in December 2015:

Specialty	Procedure
Anaesthesiology	<ul style="list-style-type: none"> • Cardiac Anaesthesia
Cardiology	<ul style="list-style-type: none"> • Left Atrial Appendage Occlusion (LAAO) • Percutaneous Coronary Intervention (PCI) • Transcatheter Aortic Valve Implantation (TAVI)
Surgery	<ul style="list-style-type: none"> • Robotic Assisted Laparoscopic Radical Prostatectomy

In March 2017, the second batch of three procedures from three specialties were endorsed:

Specialty	Procedure
Clinical Oncology	Intracavity Brachytherapy for Carcinoma Cervix Uteri
Obstetrics and Gynaecology	Robotic Radical hysterectomy
Radiology	Hepatic Transarterial Chemoembolization (TACE)

97. The Central Credentialing Committee and Chairmen of Cluster Credentialing Committees had deliberated and agreed on the verification and reporting mechanism of the endorsed HA credentialing activities in clusters. HA has promulgated to staff its policy on credentialing and defining scope of practice and shadow run of the supporting IT platform for accessing staff lists. HA's representative also attends Education Committee of HKAM to discuss and update credentialing development in HKAM and HA, and reports to HA Central Credentialing Committee regularly.

Improve clinical outcomes and patient care through clinical audit activities

98. HA has enhanced and updated the clinical audit guidelines to guide clinical specialties in performing clinical audits. The guidelines were updated and shared at eKnowledge Gateway platform under HA internal website in 1Q 2016. To develop a local risk adjusted model for intensive care outcome monitoring programme, HA has supported COC in ICU to develop a local risk adjusted model for intensive care outcome monitoring programme with assistance from The Chinese University of Hong Kong. The model and findings were presented and accepted by COC in ICU in 4Q 2016.

99. Furthermore, HA has developed specific sets of clinical indicators for service quality improvement. A Working Group on Clinical Indicators with representations from different stakeholders is overseeing the selection, development and review process of clinical indicators. As at August 2017, 22 clinical indicators have been established, while one is under the development (on Turnaround time for rapid test for influenza A&B).

Strengthen medical incidents sharing

100. HA has developed an electronic platform for staff communication on medical incidents to strengthen medical incident sharing. Information related to medical incidents (e.g. statistics, nature of broken instruments / materials, contributing factors and recommendations identified, etc.), learning and sharing materials (e.g. video clips, animated messages, presentations, etc.) are made available in the Patient Safety & Risk Management webpage under HA intranet.

101. HA has formulated and publicised the Clinical Incident Management Manual in July 2015. In 1Q 2016, the Manual was promulgated on various platforms, including Staff Sharing Forum on Sentinel and Serious Untoward Events (SE & SUE), COCs and CCs, with focus of communication and support for patients. HA will update the manual by the end of 2018.

102. HA will continue to publish Risk Alert on a quarterly basis and Annual Report on SE & SUE. Regular incident sharing sessions are held at HAHO, clusters and COCs, e.g. in 1Q 2018, two sessions were held in HAHO, and five sessions in clusters with video conferencing to other hospitals within the same cluster. Training in patient safety, including medication safety, has been incorporated into orientation programmes for interns and junior doctors.

103. To align practices for managing clinical incidents across clusters, the “Open Disclosure Policy for Clinical Incidents” was formulated and had taken effect on 1 July 2018 in HA to facilitate effective communication between patients, family, carers and healthcare providers. The need for corporate-wide training for staff on open disclosure for clinical incidents and the implications of the Apology Ordinance on daily practice was well recognised. To this end, the training curriculum framework of “Open Disclosure” was developed by the subject task force. An e-course on Open Disclosure for all doctors would be developed and put under the HSMT curriculum.

Hospital Authority
AOM\PAPER\1428
18 October 2018

**Implementation of the Recommendations of the Steering Committee
on Review of Hospital Authority**

Hospital Authority Action Plan - Summary table of specific actions

Strategic Goal and Target		Action	Status
Management and Organisation Structure			
Strengthening governance and rationalising the organisation structure			
Recommendation 1			
The HA Board, being the managing board, to play a more active role in leading and managing HA	1	Continue to strengthen stewardship by the Board along the directions of the recommendations of its corporate governance review and for ongoing strategic focus on corporate governance	On-going and continuous
	2	Set up dedicated Task Force to steer action planning for the implementation of the various recommendations of the HA Review	Completed
	3	HA Board to closely follow through implementation of the various action plans and monitor progress	Completed
Re-grouping of WTS district and MK area (KWH, WTSH and OLMH) from KWC to KCC	4	Consult stakeholders, both internal (staff, governing bodies of concerned hospitals, etc.) and external (District Councils, patients groups, community, etc.)	Completed
	5	Effect administrative arrangement for the re-grouping exercise	Completed
	6	Reorganise care provision within the new KCC and implement associated changes in KWC, having regard to : <ul style="list-style-type: none"> ➤ service planning and coordination, taking into consideration supporting network across healthcare services at acute care, extended care, primary care and community care levels ➤ service alignment with partners beyond HA, e.g. FSD and NGOs ➤ associated staff arrangement, relocation of resources ➤ infrastructure issues 	On-going and continuous

Strategic Goal and Target		Action	Status
	7	Evaluate demand and capacity gap in KCC, KWC and KEC, taking reference to service demand projection up to 2026	Completed
Demand and capacity evaluation of the remaining clusters	8	Conduct capacity-demand gap analysis on NTEC, NTWC, HKWC and HKEC	Completed
Interim measures for quick enhancement	9	Mobilise the additional 3-year funding for catch-up plans for KEC, NTEC and NTWC to help address known deficiencies in service capacity	Completed
(a) Catch up improvements for KEC, NTEC, and NTWC	10	Continue to enhance service capacity in KEC, NTEC and NTWC, including additional 36 beds to TKOH, 71 beds to PWH and a total of 122 beds to TMH and POH in 2015/16; TSWH in 2016/17; and other initiatives to enhance physical capacity of the 3 cluster	Completed
(b) Enhancing services in WTS District	11	Additional resources to WTSH and OLMH	Completed
	12	Refurbishment of HKBH	On-going
(c) Rationalise acute-rehabilitation service arrangement	13	Pilot project to drive for better vertical integration between acute and rehabilitation service for target patients residing in WTS and Yau Tsim Mong Districts	Completed
(d) Refine geographical boundaries for ambulance catchment areas	14	Fine-tune the Kowloon ambulance catchment areas to enable more speedy access to patient care in the districts	Completed
Recommendation 2			
Set up a mechanism for selection of centres for provision of highly specialised services	15	Establish mechanism to define highly specialised services, formulate selection criteria, and set parameters for highly specialised services	Completed
	16	Mechanism to cover planning of training to build up clinical expertise as well	Completed
Refine the cluster management structure	17	Revisit cluster management structure with particular regard to roles and responsibilities of CCEs	Completed

Strategic Goal and Target		Action	Status
	18	Actively engage CCEs in HAHO management functions e.g. service planning in HA's Service Budget and Planning Committee, allocation of doctor posts to clusters etc.	Completed
	19	Engage the COCs/CCs to enhance their roles and responsibilities in clinical governance under Recommendation 10	Completed
Regroup hospitals under one HCE to make HCE job portfolios comparable	20	Implement the regrouping proposals and follow up on consequential appointment of Deputy HCEs to support HCE of grouped hospitals	Completed
	21	Arrange job rotations for HCEs	On-going and continuous
Delineate the roles of hospitals within cluster	22	Develop cluster CSP (CSP for HKWC, KEC and NTEC completed) and delineate the roles and functions of hospitals within cluster	Completed
Resource Management			
Enhancing equity and transparency in resource management			
Recommendation 3			
Develop refined population-based resource allocation model	23	Undertake the necessary groundwork to prepare for model building <ul style="list-style-type: none"> ➤ Analyse healthcare utilisation of local communities to study cross-cluster flow patterns and to assess impact of different strategies for refining the cluster boundary (under Recommendation 1) ➤ Set up governance to build consensus for designated services to be counted, and conduct technical review of their costing methodologies 	Completed
	24	Develop prototype model and submit to HA Board for deliberation/endorsement	Completed
	25	Engage an external consultant to validate the approach and framework of the model	
	26	Finalise prototype model	
Analyse cluster resource utilisation to inform	27	Compare resource utilisation of clusters by the refined population-	Completed

Strategic Goal and Target		Action	Status
decision- making in service planning		based resource allocation model (i.e. with relevant adjustments)	
	28	Perform time trend analysis of cluster resource need and utilisation	
Communication and stakeholder engagement	29	Hold biannual meetings with each cluster to share ideas on model development and potential application of analysis findings	Completed
	30	Publish a consultation paper to solicit views on the model from frontline	
	31	Publish a report on the results of cluster resource utilisation analysis	Completed
Monitor progress and utilisation of catch-up funding	32	Formulate catch-up plans for KEC, NTEC and NTWC to address under-provisioned areas	Completed
	33	Review progress of 2015/16 catch-up plans to facilitate refinement of 2016/17 catch-up plans if necessary	Completed
	34	Review progress of 2016/17 catch-up plans to facilitate refinement of 2017/18 catch-up plans if necessary	Completed
Recommendation 4			
Improve and simplify the procedures of resources bidding	35	Training workshops will be organised for frontline users to consolidate the workflow in the annual planning system	Completed
	36	Over 10 system enhancements will be implemented to the annual planning system to improve system functionality, facilitate automation and reduce administrative work	Completed
Enhance transparency of the resource bidding and allocation processes	37	The “Manual on Annual Planning”, outlining the structure and process of resource bidding in HA, will be reviewed and updated for promulgation to all stakeholders	Completed
	38	Annual planning proposals formulated by clinicians with input from cluster management are deliberated and prioritised by the Service and Budget Planning Committee, membership of which includes all seven CCEs	Completed

Strategic Goal and Target		Action	Status
	39	Briefing forums will be reinforced to : <ul style="list-style-type: none"> ➤ explain the rationale and considerations behind the final decisions and allocation result of submitted proposals. Feedback concerning the submitted proposals will be given to stakeholders involved. The target groups for the forums are COC/CC members, clusters and HAHO subject officers; and ➤ share with colleagues about HA’s service development and annual plan proposal submission procedures for the next planning cycle 	Completed
Staff Management			
Enhancing consistency in staff management and strengthening staff development			
Recommendation 5			
Enhance central system to monitor creation and deletion of selected levels of senior positions	40	Formalise current mechanism for the creation and deletion of directorate positions (e.g. clinical Consultants) and Nursing Consultant positions, and extend to other grades/ranks	Completed
Enrich HAHO representation in cluster selection boards	41	Extend posts requiring mandatory HAHO representation as well as the pool of representatives with role delineation	Completed
Develop and enhance rotation programmes	42	Formulate job rotation arrangements for CEO rank and above with clear objective, selection criteria, proper selection and endorsement process, funding arrangement, roles delineation	Completed
	43	Expand central funded training places to facilitate intra-specialty rotation of clinical staff	Completed
	44	Pilot cluster-based rotation programme for cross specialty rotation of clinical staff	Completed
	45	Set up a rotation mechanism for training of clinical staff in different grades/hospitals when introducing new healthcare technology/equipment	On-going and continuous
Strengthen alignment of HR practices and	46	Strengthen existing communication and enhance partnership with cluster	Completed

Strategic Goal and Target		Action	Status
implementation of HR policies across clusters		HR in policy development and implementation	
	47	Establish system of HR audit on system and practice and standard protocols for policy formation and implementation	Completed
Enhance HA staff communication	48	Develop HR mobile solution with phased rollout	Completed
	49	Produce a Staff Communication Guidebook	Completed
	50	Conduct Staff Survey	Completed
Formulate central staff deployment plan in emergency situations	51 (a)	Establish a structured approach and relevant guidelines to enable central coordinated authority for activating central deployment plan to cope with staffing needs in emergency situations	Completed
	51 (b)	Standardize format and signatory of HA's appointment letter	Completed
Central recruitment of Resident Trainees	52	Conduct specialty-based central selection panels for Paediatrics and Psychiatry	Completed
	53	Roll out specialty-based central selection panels to all specialties to replace cluster-based selection in 2016/17 Resident Trainee recruitment and allocation exercise	Completed
Develop and implement re-employment schemes for suitable retirees to help address manpower shortage and encourage knowledge transfer [One-off funding of \$570 million]	54	Develop and implement three Special Schemes respectively for (1) clinical doctors; (2) supporting grades staff; and (3) nurses, allied health and pharmacy staff retiring in 2015/16 and 2016/17	Completed
Recommendation 6			
Strengthen governance on training	55	Set up a 2-tier governance structure for training with a dedicated committee under HRC for overall policy and steer on training	Completed
Develop mechanism to ascertain organisation training needs and	56	Develop grade-specific training curriculums	Completed
	57	Establish a structured mechanism for clusters to ascertain training needs	Completed

Strategic Goal and Target		Action	Status
development of training activities	58	Include training plan for staff when introducing new technology / services and develop a rotation mechanism for staff of different grades/hospitals other than the concerned hospital where the technology/service is introduced (Items 16 & 45 also refer)	On-going and continuous
Develop system for effective training information management and planning	59	Develop a tracking system for training programmes under the designated training fund	Completed
	60	Pilot a few key modules of a new IT system to facilitate planning, monitoring and reporting on staff training	Completed
Strengthen collaboration with external parties to enhance overall training capacity and capability	61	Develop regular liaison platforms and forums with external training partners with defined priority areas of collaboration	Completed
Utilise one-off additional funding of \$300 million to enhance training	62	Implement 11 new and scale-up training programmes (including scholarships, commissioned training, overseas training and simulation training) in 2015/16	Completed
	63	Endorse training plans and programmes of 2016/17 and 2017/18 by the CTDC	Completed
	64	Funding support for training relief to maintain service operation	On-going and continuous
Cost Effectiveness and Service Management			
Providing better services			
Recommendation 7			
Enhance the role of the HA Board in KPI performance review and KPI development process	65	KPI reports will be presented to functional committees for in-depth discussion with issues of concern highlighted to the Board for focused discussion. Through this enhanced reporting platform, the Board will be able to identify key areas for KPI development, and setting of targets and standards to drive best practices in HA services	Completed
Enhance HA's KPIs	66	Develop and refine KPIs to reflect capacity-demand gap and service efficiency on the key pressure areas, including access to Specialist	Completed

Strategic Goal and Target		Action	Status
		Outpatient Clinic (SOPC) service, OT service and access block at A&E Departments	
Enhance utilisation of KPI information to drive best practices	67	Develop an IT system with functional modules to facilitate dissemination of KPI information so that KPIs and their detailed supporting information relevant to different levels of staff can be made accessible to relevant levels of staff, including the frontline within the organisation	Completed
Recommendation 8			
Utilise FMSC to relieve pressure on O&T SOPCs	68	Build on the existing model to divert routine O&T SOPC cases in pressure areas to FMSCs to prepare for expansion of programme in KEC and NTEC. In the light of operational experience, will explore customising the model for other appropriate specialties / clusters with a view to relieving SOPC workload	On-going and continuous
	69	HAHO will strengthen its role on central coordination in formulating annual plans for a consistent service model in clusters	On-going and continuous
Employ new multidisciplinary strategy to relieve pressure on Psychiatric SOPCs	70	Through annual plan bidding, HA will enhance and strengthen the multidisciplinary teams of psychiatric SOPC for child and adolescent service and patients with CMD	On-going and continuous
	71	HA will pilot a corporate-coordinated cross-cluster booking for suitable patients with CMD from others clusters to be attended at the CMD clinic of KWC	Completed
Manage SOPC referrals	72	To manage O&T SOPC referral sources in particular, HA will engage A&E, FM and O&T on enhancement and utilisation of the referral guidelines and electronic referral system (eReferral) template on neck / back pain	Completed
	73	Enhancement and promulgation of eReferral	Completed
Employ multi-pronged strategies to generally	74	HA will carry out various renovation and redevelopment/expansion projects	On-going and continuous

Strategic Goal and Target		Action	Status
improve the capacity and efficiency		to expand physical capacity for SOPC service	
	75	Production of “Specialty-based SOPC Waiting Time Analysis Charts” in Management Information Portal for easy retrieval and timely access to most up-to-date analysis	Completed
	76	Indicators are being developed to assist the monitoring of SOPC service throughput, new case booking pattern, service demand and supply relationship. SOPC service throughput indicators on SOPC attendances per doctor ratio will be explored to become HA’s KPIs	Completed
	77	Subject to results of the GOPC PPP Interim Review, to extend the Programme to all 18 districts in phases (Item 95 also refers)	Completed
Align practices of different clusters and minimise cross-cluster variance in waiting time	78	Further to the pilot run in QEH, the SOPC Phone Enquiry System will be implemented in the other six clusters	Completed
	79	HA will conduct a comprehensive review of appointment scheduling practices of SOPC and publish a SOPC Operation Manual to align different practices in SOPC	Completed
	80	To facilitate patient-initiated cross-cluster new case booking, HA has enhanced transparency of SOPC waiting time information, which will facilitate patients’ understanding of the waiting time situation in HA and assist them to make informed decisions in treatment choices and plans	Completed
	81	HA will pilot a mobile App to facilitate patients’ choice on cross-cluster new case booking in the specialty of gynaecology. Upon review, the application will be further rolled out to other appropriate specialties	Completed
Ensure A&E patients with pressing medical needs received timely medical treatment	82	Re-engineer the work process for Category III patients aiming for early assessment and intervention	Completed
	83	Deploy additional medical and nursing manpower to pressure specialties including A&E Departments to sustain	On-going and continuous

Strategic Goal and Target		Action	Status
		the operation of A&E Departments and improve the waiting time for Category III patients	
Improve the waiting time of Category IV and Category V patients in A&E Departments	84	Develop a transparent mechanism and an open platform for releasing the estimated waiting time to public	Completed
	85	Further expand the scale and coverage of A&E Support Session Programme	Completed
Development of KPI to monitor access block problem	86	Develop an Access Block KPI to monitor the access block problem	Completed
Strengthening of HAHO's input and enhancement of intra-cluster collaboration	87	HAHO to actively provide input and support for cluster strategies from policy and resource allocation levels to cluster-based task forces in KCC and NTEC	Completed
	88	Cluster-based task forces to coordinate intra-cluster collaboration and mobilise cluster resources to address the problem	Completed
Building up of capacity	89	Continued efforts in increasing service capacity in KCC and NTEC through addition of beds, refurbishment projects, minor works projects, and planning of major medical facilities to meet service demand of the clusters	On-going and continuous
	90	Capacity gap revealed during the process to be addressed through annual planning exercises	On-going and continuous
Management of service demands	91	Implement measures to reduce avoidable hospital admissions of elderly patients, e.g. community geriatric assessment service at A&E level, enhancing day care service, fast track clinics	On-going and continuous
	92	Reduce length of stay for patients for better service demand management	On-going and continuous
	93	Dashboard to provide real time information to facilitate bed coordination	Completed
Recommendation 9			
Increase service capacity	94	Continue to enhance the capacity of primary care services provided by HA	On-going and continuous
	95	Strengthen partnership with the private sector on primary care via extension in	Completed

Strategic Goal and Target		Action	Status
		phases of the GOPC PPP to enhance primary care capacity for the management of patients with chronic diseases and provide choice to patients (Item 77 also refers)	
	96	Increase the capacity to support elderly patients in RCHEs through the CGAT service	On-going and continuous
	97	Increase the capacity of hospital beds	On-going and continuous
Review and develop service delivery models and strengthen partnership with community partners	98	Enhance services in collaboration with the DH to provide influenza vaccination to patients with chronic disease and elderly living in the community	Completed
	99	Work with NGO, Social Welfare Department and FHB to develop a collaborative service model with enhanced geriatric support in a large-scale old age home in Lam Tei to facilitate ageing in place and reduce unnecessary hospitalisation	On-going
	100	Partner with NGO to provide infirmary service to persons requiring long term institutional health and social care via the pilot Infirmary Service PPP	Completed
	101	CGATs work in partnership with Palliative Care teams and NGOs to improve medical and nursing care to elderly patients living in RCHEs facing terminal illness, and to provide training for RCHEs staff	On-going and continuous
	102	Strengthen the structured palliative care training for different healthcare disciplines	On-going and continuous
	103	Further develop the Community Health Call Centre service to provide telephone advice and support to diabetes mellitus patients in Medical SOPCs on disease management	On-going and continuous
Strengthen patient empowerment and engagement	104	Revamp the Smart Patient Website to provide more information to support carers of the elderly	Completed
	105	Review and refine the service model and contractual partnership with the NGOs on the Patient Empowerment Programme to support Patients with	Completed

Strategic Goal and Target		Action	Status
		diabetes mellitus or Hypertension and enhance service quality	
	106	Review and strengthen the role of Patient Resource Centres as a platform to coordinate community partners and patient groups, and to help strengthen the participation of patient groups	Completed
	107	Continue to implement Corporate PES Programme to collect patient feedback on HA services and identify areas for improvement	On-going and continuous
	108	Further increase patient representatives' participation in formal platforms to provide advice and feedback on service development and patient care	On-going and continuous
Overall Management and Control			
Enhancing the safety and quality of services			
Recommendation 10			
Strengthen the roles of COCs on clinical governance	109	Require COCs/CCs to enhance their roles and responsibilities in clinical governance, specifically in setting service standards, developing clinical practice guidelines, education and training, conducting clinical audits, managing clinical risk management and introduction of new technology and service development	Completed
	110	Promulgate standardised set of Terms of Reference of COCs/CCs	Completed
	111	Evaluate the implementation by inviting COCs/CCs to conduct self-assessment on their enhanced roles and areas for improvement	Completed
Enhance the role of COS with greater emphasis on clinical governance	112	Engage COSs and doctor groups on the enhanced role of COS, particularly in quality of patient care and patient safety	Completed
	113	Specify COS management functions as related to clinical governance in COS appointment and staff appraisal procedure	Completed
Refine COC/CC/service committees relationship with a view to reducing	114	Improve the annual planning process to further reduce the administrative work in annual resource planning. Key	Completed

Strategic Goal and Target		Action	Status
their administrative work in annual resource planning and clinical service development		stakeholders in COCs/CCs will be engaged through training workshops and feedback processes to better utilise the annual planning cycle for prioritisation of resource bids put forward by hospital service units so as to reduce abortive work at frontline level	
Develop a system of credentialing and defining scope of practices	115	Implement the established vetting mechanism of credentialing activities in HA through the COCs/CCs, Central and Cluster Credentialing Committees	Completed
	116	In collaboration with Cluster Credentialing Committees, develop mechanism of defining scope of practice, maintenance of staff lists and regular reporting of HA endorsed credentialing activities	Completed
	117	Communicate with HK Academy of Medicine on HA's credentialing development and discuss the future development	Completed
Improve clinical outcomes and patient care through clinical audit activities	118	Enhance and update the clinical audit guidelines to guide clinical specialties in performing clinical audits	Completed
	119	Support COC (ICU) to develop a local risk adjusted model for intensive care outcome monitoring programme	Completed
	120	Develop specific sets of clinical indicators for service quality improvement	Completed
Strengthen medical incidents sharing	121	Develop an electronic platform for staff communication on medical incidents	Completed
	122	Publicise and implement the Clinical Incident Management Manual, with focus of communication with and support for patients	Completed
	123	Publish HA Risk Alert (HARA) and annual report and organise incidents sharing sessions at HAHO, cluster forums and COCs	On-going and continuous
	124	Continue to integrate patient safety in training to interns and junior doctors	On-going and continuous

Abbreviation list

A

A&E	Accident and Emergency
AHNH	Alice Ho Miu Ling Nethersole Hospital

C

CC	Central Committee
CCE	Cluster Chief Executive
CEO	Chief Executive Officer
CGAT	Community Geriatric Assessment Team
CMC	Caritas Medical Centre
CMD	Common Mental Disorders
COC	Coordinating Committee
COSs	Chiefs of Service
CSP	Clinical Services Plan
CTDC	Central Training and Development Committee

D

Ds	Directors
DH	Department of Health
DHCE	Deputy Hospital Chief Executive
DM	Directors' Meeting
D(CS)	Director (Cluster Services)

E

EC	Executive Committee
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F

FHB	Food and Health Bureau
FM	Family Medicine
FMSC	Family Medicine Specialist Clinic
FSD	Fire Services Department

G

GH	Grantham Hospital
GOP	General Out-patient
GOPC	General Out-patient Clinic

H

Hs	Heads
HA	Hospital Authority
HAHO	Hospital Authority Head Office
HCE	Hospital Chief Executive
HGC	Hospital Governing Committee
HDP	Hospital Development Plan
HHR	Head of Human Resources
HKAM	Hong Kong Academy of Medicine
HKBH	Hong Kong Buddhist Hospital
HKEC	Hong Kong East Cluster
HKWC	Hong Kong West Cluster
HR	Human Resources

HRC	Human Resources Committee
HSS	Highly Specialised Services
I	
ICU	Intensive Care Unit
IT	Information Technology
K	
KCC	Kowloon Central Cluster
KCH	Kwai Chung Hospital
KEC	Kowloon East Cluster
KH	Kowloon Hospital
KPI	Key Performance Indicator
KTDA	Kai Tak Development Area
KWC	Kowloon West Cluster
KWH	Kwong Wah Hospital
L	
LKB	Lai King Building
N	
NAH	New Acute Hospital
NDH	North District Hospital
NGO	Non-Governmental Organisation
NTEC	New Territories East Cluster
NTWC	New Territories West Cluster
O	
OLMH	Our Lady of Maryknoll Hospital
OT	Operating Theatre
O&T	Orthopaedics & Traumatology
P	
PES	Patient Experience and Satisfaction
POH	Pok Oi Hospital
PPP	Public-Private Partnership
PMH	Princess Margaret Hospital
PWH	Prince of Wales Hospital
PYNEH	Pamela Youde Nethersole Eastern Hospital
Q	
QEH	Queen Elizabeth Hospital
R	
RAE	Resource Allocation Exercise
RCHEs	Residential Care Homes for the Elderly
RT	Resident Trainee
S	
SBPC	Service and Budget Planning Committee
SE & SUE	Sentinel and Serious Untoward Events
SOP	Specialist Out-patient

SOPC Specialist Out-patient Clinic
SRRS Special Retired and Rehire Scheme

T

TKOH Tseung Kwan O Hospital
TMH Tuen Mun Hospital
TSWH Tin Shui Wai Hospital
TWEH Tung Wah Eastern Hospital

W

WCHH Wong Chuk Hang Hospital
WTS Wong Tai Sin
WTSH Wong Tai Sin Hospital

Y

YCH Yan Chai Hospital